EXHIBIT 5

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

JACK REESE, FRANCES ELAINE PIDDE, JAMES CICHANOFSKY, ROGER MILLER, GEORGE NOWLIN and RONALD HITT, on behalf of themselves and a similarly situated class,

Plaintiffs,

v.

CNH GLOBAL N.V., formerly known as Case Corporation, and CNH AMERICA LLC,

Defendants.

Hon. Patrick J. Duggan

Case No. 04-70592

Class Action

/

Roger J. McClow (P27170)
David R. Radtke (P47016)
Darcie R. Brault (P43864)
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/

PLAINTIFFS' FIRST REQUESTS FOR ADMISSION

Plaintiffs, pursuant to Federal Rules of Civil Procedure 26 and 36, hereby request that CNH Global N.V. respond to the following Requests for Admission, in writing and under oath, within thirty (30) days of service hereof.

DEFINITIONS

Unless otherwise indicated, the following definitions shall be applicable to these Interrogatories:

1. The term "Company" as used herein means J. I. Case, Case Corporation, Case LLC, CNH America LLC, CNH Global N.V., CaseNewHolland, Inc., Case New Holland, Inc., Fiatallis North America, Inc., Fiat SPA, Fiat Acquisition Company, their predecessors, parents, subsidiaries and divisions and the employees, representatives and agents of these entities.

2. "Class Member" means a retiree or surviving spouse described in the revised definition of the Class set forth in Paragraph 7 of the Stipulated Order entered November 16, 2007.

3. "Class" means all Class Members and Dependents.

4. "Current Plan" means the medical, dental, vision, hearing aid and prescription drug plan the Company is currently providing under the 1998 Group Benefit Plan.

5. "Current Plan Participant" means any Class Member or any Dependent who is enrolled in the Current Plan.

6. "Dependent" means a dependent spouse or dependent child of a retiree Class Member or a dependent child of a surviving spouse Class Member.

7. "2005 Plan Participant" means any participant in the CNH/UAW Group Benefit Plan 2005.

8. "Proposed Plan Participant" means any Class Member or any Dependent the Company proposes to enroll in the Proposed Plan.

9. "Proposed Plan" means the plan of medical, dental, vision and prescription drug benefits that the Company has proposed to provide to the Class pursuant to the Draft Summary Plan

Description dated January 23, 2013 and the CNH Plan Document - 2009 as clarified and modified by Bobby Burchfield's letter to Darcie R. Brault of March 1, 2013.

10. The "Retiree Medical Savings Account (RMSA)" means the Retiree Medical Savings Account as described in the Summary Plan Description dated July 2005.

PLEASE ADMIT:

1. Admit that the precise plan proposed by the Company to implement with respect to the Class is contained in its entirety[1] in Exhibits A and B, attached.

2. Admit that the 2005 Plan Participants received a $7,500 payment to their RMSA when they retired.

3. Admit that the Class will not receive a $7,500 payment to an RMSA under the Proposed Plan.

4. Admit that the 2005 Plan Participants who were Medicare-eligible retirees received annual Company contribution payments of $50/year of credited service up to $1,500 between the date of retirement and 2011.

5. Admit that the Class will not receive the annual payments referenced in 4, above, under the Proposed Plan.

6. Admit that a Proposed Plan Participant's coverage will end if a premium payment is missed.

7. Admit that the Proposed Plan will cover:

> All former bargaining unit employees who retired under the Case Corporation Pension Plan for Hourly Paid Employees after July 1, 1994, and who retired on or before April 1, 2005 (other than former employees eligible for or receiving retirement benefits under the deferred vested provisions of the Pension Plan and former employees hired after May 18, 1998), and all surviving spouses of those former bargaining unit employees.

[1] There are no additional plan documents which limit or broaden the proposed plan terms.

Respectfully submitted,

McKNIGHT, McCLOW, CANZANO,
SMITH & RADTKE, P.C.

By: _____

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dbrault@michworklaw.com

Dated: March 14, 2013

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

JACK REESE, FRANCES ELAINE PIDDE, JAMES CICHANOFSKY, ROGER MILLER, GEORGE NOWLIN and RONALD HITT, on behalf of themselves and a similarly situated class,

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Washington, D.C. 20005
(202) 756-8000

PROOF OF SERVICE

STATE OF MICHIGAN)
)ss
COUNTY OF OAKLAND)

KAREN ANN PURSLOW, being first duly sworn, deposes and says that on the 14th day of March 2013, she served Plaintiffs' First Interrogatories to Defendant, Plaintiff's Fourth Request for Production of Documents, Plaintiffs' First Requests for Admission and Proof of Service of same upon:

Bobby R. Burchfield, Esq.
Douglas G. Edelschick, Esq.
McDERMOTT WILL & EMERY
600 Thirteenth Street, N.W.
Washington, D.C. 20005

by email.

KAREN ANN PURSLOW

Subscribed and sworn to before
me this 14th day of March 2013.

SANDRA J. COWELL, Notary Public
Wayne County, MI (Acting in Oakland)
My Commission Expires: Sept. 30, 2018

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Employee Group Insurance Plan

for Hourly Employees of Case New Holland Inc.

United Auto Workers

Summary Plan Description
March 21, 2005 to April 30, 2011

Contents

About This Handbook

This handbook is a summary of important information about your benefits. The benefits described here go a long way toward providing financial protection for you and your family while you're a Case New Holland Inc. ("CNH") employee. Understanding your benefit plans is essential for both your well-being and to ensure you're getting the most out of your benefits.

You are encouraged to familiarize yourself with this material so you'll have a better understanding of your benefits—and know where to look for details and specific information when you have questions.

Official Plan Documents

This handbook describes the main provisions of the Case New Holland Inc. Employee Group Insurance Plan (the "Plan"). However, not every detail is included. The official Plan documents and labor agreements govern your rights and benefits. If there is any variance between the contents of this handbook and the official Plan documents and labor agreements, those documents or agreements will govern. If you would like to see, or obtain copies of, these documents, you may arrange to do so through your local Human Resources Office.

This summary reflects the provisions of the Plan as in effect on April 1, 2005 in accordance with the terms of the collective bargaining agreement in effect from March 21, 2005 to April 30, 2011. For the period May 3, 2004 through March 31, 2005, the medical, dental, vision and hearing program plan design features which were in place on May 2, 2004 and are described in the handbook dated May 1998 to May 2004 continued except that, effective December 31, 2004, the Wellmark PPO Plan and the DentaCare Plan were eliminated.

Group insurance benefits for employees who retired before December 1, 2004 are not covered by this handbook and should refer to the Benefits Handbook in effect for May 1998 to May 2004.

Plan changes that are indicated as being effective on a specific date will be effective as of such date provided you are actively at work on such date or the last regularly scheduled working day before such date. If you are not actively at work on such dates, the changes will become effective upon your return to active work unless otherwise noted.

An amendment or termination of the benefit plans sponsored by CNH may affect not only the coverage of active employees (and their covered dependents) but also of COBRA participants and former employees who retired, died or otherwise terminated employment.

Nothing in this handbook should be interpreted as a guarantee of employment, or as the right of any employee to continue in the employment of CNH.

Eligibility, Enrollment and Termination of Coverage—Section A

Eligibility, Enrollment and Termination of Coverage—Section A

The eligibility, enrollment and termination rules discussed in this section A are not the only rules that govern whether you or your eligible dependent may receive a benefit. You should always read this section A **and** the section describing the particular benefit for which you are applying to determine all of the rules, exclusions, limitations and requirements applicable to that particular benefit.

Employee Eligibility
You are eligible for coverage if you are a regular, full-time, active, hourly CNH employee covered by the collective bargaining agreement between CNH and the UAW.

You are considered *actively at work* (a) if you are performing your regular duties; or (b) you performed your regular duties on your last scheduled workday. You must perform the duties at your place of business or a location where you were required to travel to perform business.

You become eligible for coverage on the day following the completion of the length of continuous service noted below, provided that you are actively at work on that day (unless otherwise required by federal regulation). If you are absent from work due to a health condition, you will be considered actively at work. If you are not actively at work for any other reason, your coverage will not begin until you return to active employment.

Waiting Periods for Employees Hired or Rehired on or After May 14, 1998:

- Life, AD&D, and CNH Health Care Plans — 3 months
- A&S Benefits — 3 months
- Dental Plan — 18 months
- Vision Plan — 18 months
- Long Term Disability — 24 months

If you are on an unpaid leave of absence, you are eligible for coverage in accordance with the collective bargaining agreement.

Employees hired on or after May 14, 1998 are **not** eligible for Survivor Income Benefits.

Dependent Eligibility
If you enroll for coverage, you may enroll your eligible dependents for coverage under the CNH Health Care Plans, the Dental Plan and the Vision Plan. The Life Insurance, AD&D, A&S Benefits and Long Term Disability Plans are available only to employees.

If you enroll for coverage, you may also enroll your eligible dependents for coverage. Eligible dependents include your:

- Spouse, as defined by the laws of your state.
- Unmarried children under age 19, including:
  - — Natural children;
  - — Legally adopted children;
  - — Stepchildren living with you; and
  - — Children in your legal custody by court decree, who permanently live in your household, dependent primarily on you for financial support, and live with you in a normal parent-child relationship.
- Unmarried, dependent children at least age 19, but under age 25, who:
  - — Have the same permanent, legal residence as you;
  - — Are primarily dependent upon you for maintenance and financial support; and
  - — Are in regular, full-time attendance at an accredited secondary school, college, or university.
- Unmarried, dependent children who are mentally or physically disabled.

The Plan Administrator establishes whether a student is attending an accredited school using the reference book, *Accredited Institutions of Postsecondary Education*, published by the American Council on Education.

If you wish to continue coverage for a dependent over the age of 19, you must provide proof of eligibility status, as requested by the Plan Administrator.

No other dependents are eligible for coverage, even if they live with you and depend on you for support.

Eligible dependents do not include:

- Your (or your spouse's) parents or grandparents, even if living with you and dependent upon you for support;
- Your married children;
- Your sister or brother;
- Your brother-in-law or sister-in-law;
- Your grandchildren, unless they become your legal dependents by legal adoption or guardianship;
- Your stepchildren who do not live with you, unless you or your spouse are required to provide them with coverage under the terms of a divorce decree; or
- Your aunts, uncles, or cousins.

An eligible dependent child cannot be actively serving in the armed forces of any country.

Disabled Child Eligibility

Your unmarried, disabled child is eligible for continued medical coverage if the child is:

- Physically or mentally disabled;
- Incapable of self-support upon reaching age 19 or 25—when eligibility would otherwise end;
- Unmarried; and
- Claimed as a dependent on your Federal Income Tax Return.

If you wish to continue coverage for a disabled child:

- You must provide proof of the child's disability that is acceptable to the plan administrator within 30 days after your child reaches the age (19 or 25) when eligibility would otherwise end and, subsequently, upon request from CNH or the plan administrator.

ENROLLMENT

You must enroll to receive Medical, Prescription Drug, Dental, Vision and Flexible Spending Account benefits. Please note that you are automatically enrolled for Prescription Drug coverage if you enroll for Medical coverage. You must also enroll to obtain optional contributory life insurance.

Coverage for the following benefits is automatically available to you: Basic Noncontributory Life Insurance, Accidental Death and Dismember benefits, Survivor Income benefits, Weekly Accident and Sickness benefits, Long Term Disability benefit and Layoff Disability benefits.

Enrollment Categories
You choose one of these four enrollment categories when you enroll:

- Employee Only;
- Employee + Spouse;
- Employee + Child(ren); and
- Employee and Family.

If you and your spouse both work for CNH:

- You may not have duplicate coverage, *i.e.*, you cannot be covered both as an employee and as a spouse of an employee; and
- Both of you must choose:
  - — Employee Only coverage; or
  - — Only one of you must choose Employee and Family coverage; or
  - — One of you can choose Employee Only and one of you can choose Employee and Child(ren).

Initial Enrollment
You enroll for coverage when you first become eligible. You enroll your eligible dependents at the same time you enroll.

When you enroll, you may enroll:

- You, the eligible CNH employee, only; or
- You, your spouse, and/or your eligible dependent children.

Annual Enrollment
Each year you will be provided the opportunity to change your benefit election for the upcoming calendar year. After the beginning of a calendar year, you may not change your coverage election unless you encounter a Change in Family Status as permitted under Section 125 of the Internal Revenue Code.

In the event that you encounter a qualifying Change in Family Status, you will be given the opportunity to change your annual benefit election, provided you do so within 30 days of the qualifying event. Otherwise, enrollment election changes can only be made during the annual enrollment period.

Change in Family Status
Your election remains in effect the entire calendar year unless you become ineligible. You may change your election during the year only if you have an eligible Change in Family status. Eligible changes include:

- You get married, divorced, legally separated, or have your marriage annulled;
- You have a baby, adopt a child, have a child placed with you for adoption, or your spouse or dependent dies;
- You, your spouse, or your dependent starts or ends employment;
- You, your spouse's, or your dependent's work schedule changes (a switch from part-time to full-time employment and vice versa, a strike or lockout, or the start or termination of an unpaid leave of absence);
- Your dependent becomes eligible or ineligible for coverage (he or she reaches the plan's age limit, becomes or ceases to be a student, gets married, or joins the military); or
- Your, your spouse's, or your dependent's residence changes.

However, you may change your coverage during the year only if:

- The change in status causes you, your spouse, or your dependent to lose or gain eligibility for coverage under the plan (or under your spouse's or dependent's plan); and
- Your election change reflects the gain or loss of coverage.

If you have a Change in Family Status:
Contact your employee benefits representative for the appropriate forms. Complete and return a new enrollment form within 30 days of the change. You must return the appropriate forms within 30 days after the Change in Family Status occurs for your change in coverage to be effective as of the date of the family status change. If you fail to return the appropriate forms, your change in coverage will not be effective until the first day of the following plan year.

Qualified Medical Child Support Order
A qualified medical child support order is an order or judgment from a state court – served on CNH or the agent for service of legal process – directing the plan administrator to cover a child for benefits under the health care plans. Coverage will be provided in accordance with federal and applicable state law. Federal law provides that a medical child support order must meet certain form and content requirements to be a qualified medical child support order. When an

order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid. Coverage will not become effective until the plan administrator determines that the order is a qualified medical child support order.

Coverage Begins
If you enroll within 30 days after the date you first become eligible, your coverage begins on the first day following the completion of three months of continuous service.

If you enroll for coverage during the annual enrollment period subsequent to your initial enrollment period, your coverage begins on the first day of the first plan year next following the date you enroll.

Coverage for your enrolled dependents begins on the same day your coverage begins. Dependent coverage shall be effective on the date the person becomes your dependent, provided enrollment is made within 30 days of the date you acquire the dependent.

If you are absent from work due to a health condition on the date coverage is scheduled to begin, you will be considered actively at work. If you are not actively at work for any other reason on the date coverage is scheduled to begin, your coverage will begin the first day you return to active work..

TERMINATION OF COVERAGE

Employee
Your coverage will end the day on which any of the following occurs:

- You are no longer eligible for coverage;
- Your employment is terminated (your last day of work);
- You fail to make a required contribution to the cost of your coverage; or
- The Plan is terminated.

If you fail to make a required contribution to the cost of your coverage, your coverage will end as of the last day of the last period for which you made a required contribution.

Spouse
Coverage for your spouse will end the day on which the earliest of the following occurs:

- The date your coverage ends;
- The date the marriage is legally dissolved;
- The date your spouse is no longer enrolled for coverage; or
- The date your spouse enters the armed forces.

Child
Coverage for your child will end the day on which the earliest of the following occurs:

- The date your coverage ends;
- The date your child is no longer enrolled for coverage;
- The date your child enters the armed forces; or
- The date your child is no longer an eligible dependent.

If a covered person is hospitalized the day coverage ends or is reduced, full benefits for the hospitalized patient will continue until he or she is released.

Continuation of Coverage in Certain Situations
In certain situations where you are not actively at work and your benefits would otherwise end, you may be deemed to be actively at work so that you may continue certain benefits. The following sections describe those situations, which benefits will be continued and for how long the benefits will be continued.

- Life Insurance benefits shall continue to be payable for thirty-one days after termination of coverage.
- On the date of you lose coverage under this plan, you will be offered COBRA continuation coverage for certain health care benefits.

Lay-Off
The following group coverage that was in effect for you as an active employee shall be continued in effect as stated below if you cease active work due to a lay-off:

- Coverage for employees only
  - Life Insurance Benefits
  - Accidental Death & Dismemberment Benefits
  - Survivor Income Benefits (Transition and Bridge)
- Coverage for Employees and Dependents
  - Medical Benefits
  - Prescription Drug Benefits
  - Dental Benefits
  - Vision Benefits

If you are placed on lay-off, you will have certain coverage continued according to the following schedule:

- Coverage Based on SUB Eligibility

  All coverage's listed above shall be continued for one full calendar month of lay-off, not to exceed twelve (12) months, for each full four weeks of benefits to which your SUB eligibility would entitle you on the basis of your seniority and SUB eligibility as of the last day of work prior to lay-off.

- Coverage Based on Seniority for employees hired prior to May 14, 1998.

Years of Seniority	Weekly Benefit	Maximum Duration
1 – 10	$200	26 Weeks
10+	$200	52 Weeks

- Employees hired on or after May 14, 1998

Years of Seniority	Weekly Benefit	Maximum Duration
1 – 5	$100	13 Weeks
5+	$125	26 Weeks

The continuation will be based upon the greater of the above calculations. You will have the conversion privileges available upon expiration of the period of continued group coverage's listed above.

An employee with ten or more years of seniority at the time of lay-off due to a full or partial plant closing will receive an additional twelve months of Life Insurance and Medical coverage (including prescription drugs), excluding Dental and Vision benefits.

- Conversion Privileges

The life insurance conversion privileges shall be available to employees upon expiration of the period of continued group coverage listed above.

Disability Leave of Absence

If you are disabled, you will be eligible to continue coverage at applicable rates in effect for active employees for Life Insurance, Medical, Dental, Prescription Drug, and Vision for the period during which you receive A&S Benefits. If you qualify for Long-Term Disability Benefits, you will be eligible to continue coverage for Basic Life Insurance, Medical, Dental, Prescription Drug and Vision at the applicable rates in effect for retirees.

The life insurance conversion privileges are available to you upon expiration of the period of continued group coverage listed above.

Maternity Leave of Absence
If you are placed on leave of absence for maternity, you will be permitted to continue Life Insurance, Medical, Dental, Prescription Drug, and Vision coverage at normal active employee rates for yourself and your eligible dependents, if required, for up to twelve (12) months following the date the leave of absence commenced.

Other Leave of Absence

Union Business
Medical, Dental, Prescription Drug and Vision coverage will be continued at CNH expense consistent with that applicable to active employees, during an approved Leave of Absence requested by the Local Union to permit an employee to work on a full-time basis for the Local Union for a period not longer than the balance of the month in which the leave commenced plus the following full calendar month. Thereafter, the employee shall be entitled to continue such coverage by paying the full cost thereof.

Personal
The group coverage (Life Insurance, AD&D, Survivor Income Benefits, Medical, Dental, Prescription Drug and Vision) shall be continued in force for the month following the month in which the leave commences.

Contested Worker's Compensation Claim
In the event of a contested claim for Worker's Compensation Benefits, the following procedure will be followed:

With regard to medical services, CNH physicians, at their discretion, may either treat you, refer you to an outside physician, or permit you to go to a physician of your choice (subject to applicable state law).

You shall receive an amount of money equal to your current A&S Benefit rate, but this benefit will not be considered either A&S Benefits or Worker's Compensation until such time as the dispute is finally resolved.

You will be required to sign a reimbursement form which will provide that any Worker's Compensation judgment in your favor that duplicates a payment previously made by CNH, will be returned to CNH by your, or deducted from any final settlement CNH may be required to make.

Network and Non-Network Medical Plans— Section B

Network and Non-Network Medical Plans—Section B

Frequently Used Telephone Numbers	
Telephone Number	**Information**
1-800-826-9781	**Fiserv Health – Wausau Benefits Customer Services**
1-800-827-6730	**Bowers & Associates,** precertification administrator.
1-800-207-2568 TDD and hearing impaired: **1-800-899-2114**	**Walgreens Health Initiatives**, prescription drug benefits.

CNH provides affordable, comprehensive health care—through local Medical Networks of physicians and hospitals—to employees, regardless of when hired, and to their eligible dependents. The network is available in a majority of locations. This is a Preferred Provider Option (PPO) managed care program. Employees may choose to be treated in or out of the network each time they need medical treatment.

Employees and dependents who receive care from network providers receive a higher level of benefit than those that receive care from a provider who is not a member of the network.

In the case of an employee who does not reside in a network location, the Non-Network Plan will be the employee's plan.

Opt-Out Credit For Active Employees Only

Effective April 1, 2005, active employees who do not elect any group health coverage (Medical, Dental and Vision coverage) and are not covered as a dependent under another CNH group health plan will be eligible to receive a yearly credit of $1,000. This credit will be added to your pay, divided equally among 48 pay periods. This credit is taxable and will not constitute compensation for any employee benefits purposes. This opt-out credit will be prorated for 2005 due to the new group health benefit plan design effective April 1, 2005.

The opt-out credit is not available for inactive employees, retirees, surviving spouses or employees receiving long-term disability benefits. Further, if you are a new employee, you are not eligible for the opt-out credit until you satisfy your initial waiting period for enrollment for medical benefits, plus your enrollment window (30 days after your eligibility date). Payments of the opt-out credit stop if you enroll in Medical, Dental or Vision coverage.

Contributions

Beginning April 1, 2005, contributions for Medical coverage for active employees, employees on layoff, employees on A&S benefits and other similarly situated employees will be equal to the contributions required of CNH non-represented employees for enrollment in the Network Medical Plan (based upon enrollment category). Effective January 1, 2006 and January 1, 2007, your contribution levels will be adjusted in the same manner as the non-represented employees for the same enrollment category. Beginning on January 1, 2008, your required contributions will be set at 15% of the total plan cost projected for each plan year based upon the UAW covered employee plan experience. Plan cost is comprised of projected claim and administrative costs for each specific category of coverage (*i.e.* single, dependent, spouse and family categories). Your contributions will be taken on a pre-tax basis from the first four paychecks per month on a generally equal basis.

From April 1, 2005 through December 31, 2007, contributions for Medical coverage for retirees who retire on or after December 1, 2004, surviving spouses and Long Term Disability participants will be equal to the contributions required from the CNH non-represented retirees for enrollment in the Network Medical Plan with single coverage. The family rate will be two times the single rate. Beginning on January 1, 2008, the required contributions will be adjusted to reflect a formula based on the UAW participant experience. Under this formula the increase in total plan cost from prior year will be projected to the current year using UAW participant experience. Your contributions based on this increase in total plan cost will be adjusted to cover 60% of the projected additional total plan cost for 2008 and each subsequent year.

Annual Deductible

Each dependent enrolled in the Plan must meet a separate per person deductible each year before the Plan will pay benefits for treatment. Two or more covered dependents may help the family meet a family deductible.

The deductible starts over each January 1. You cannot carry over the deductible from year to year.

Medical Network: Summary

The Medical Network is made up of physicians, hospitals, and other health care professionals who have contracted with the claims administrator to provide appropriate treatment at predetermined rates. CNH does not control which hospitals and physicians participate. CNH is not a party to any agreements between the claims administrator and the specific hospital or physician. CNH is not responsible for and makes no representations regarding the care provided by professionals in the Medical Network.

The network is available in designated ZIP Code areas. You will be notified where the network is available each year at enrollment.

Each time treatment is needed, you may choose to be treated in the network or out of the network.

You receive a higher level of benefits if treatment is received from a physician or hospital in the Medical Network.

Receiving In-Network Benefits
You choose a Preferred Provider from the Provider Directory. Always carry your network identification card and show it whenever you receive medical services. If it is lost or stolen, call Customer Services.

You precertify non-emergency inpatient hospital care by calling the number on your ID card. In most cases, you do not have to file a claim form.

You should contact Customer Services if you have questions. A Customer Services representative is available to answer your questions or to help with your problem.

You obtain prescription medicine through Walgreen's Health Initiatives-affiliated pharmacies or through Walgreens Health Initiatives mail-order service.

Receiving Out-of-Network Benefits
You receive treatment from any physician.

When you visit your family physician or a specialist, you receive out-of-network benefits. You pay the full cost of the treatment and the Plan reimburses you for a portion of the covered expenses, generally 65% of reasonable charges, after you meet a deductible.

If you require treatment from a hospital, you may choose any hospital. You must precertify your hospital stay by contacting the precertification administrator. If you do not precertify, your benefits will be reduced. If you follow the precertification rules, the Plan reimburses you for 65% of the covered expenses, after you meet a deductible.

You must file a claim form to be reimbursed. Claim forms may be obtained by calling Customer Services.

You obtain prescription medicine through Walgreen's Health Initiatives-affiliated pharmacies or through Walgreens Health Initiatives mail-order service.

Network Medical Plan Covering Employees Effective April 1, 2005:

	In-Network*	Out-of-Network**
Annual Deductible	$200 per person $400 per family	$500 per person $1,000 per family
Annual Out-of-Pocket Maximum		
Base pay under $40,000* **	$1,000 per person/$2,000 per family	$2,000 per person
Base pay $40,000-$59,999	$1,500 per person/$3,000 per family	$3,000 per person
Base pay $60,000-$79,999	$2,000 per person/$4,000 per family	$4,000 per person
Base pay $80,000 or higher	$2,500 per person/$5,000 per family	$5,000 per person
Coinsurance	85% after deductible (deductible does not apply to routine doctor office visits or preventive care)	65% after deductible
Allergy Tests and Treatments	Allergy injections: $20 copayment each visit	65% after deductible
Chiropractic (Medically Necessary)	$20 copayment per visit	65% after deductible
Durable Medical Equipment Including Necessary Replacement or Repairs (Crutches, wheelchairs, hospital bed, respirator—including oxygen and other gases—and their administration) (also includes one hearing aid per 36 months)	85% after deductible. Subject to a calendar year maximum of $2,500 (combined in- and out-of-network).	65% after deductible. Subject to a calendar year maximum of $2,500 (combined in- and out-of-network).
Consumable Medical Supplies (*e.g.* Ostomy supplies, catheters, etc.)	85% after deductible	65% after deductible

	In-Network*	Out-of-Network**
Emergency Ambulance	85% after deductible	Network level benefit if care meets administrator's definition of emergency. Otherwise, 65% after deductible.
Emergency Care	85% after deductible	Network level benefit if care meets administrator's definition of emergency. Otherwise, 65% after deductible.
Emergency Care (Physician's office)	$20 copayment per visit	Network level benefit if care meets administrator's definition of emergency. Otherwise, 65% after deductible.
External Prosthetic Devices Including Necessary Replacement	85% after deductible. Subject to a calendar year maximum of $3,000 (combined in- and out-of-network).	65% after deductible. Subject to a calendar year maximum of $3,000 (combined in- and out-of-network).
Necessary Repairs to External Prosthetic Devices	85% after deductible	65% after deductible
Family Planning: Infertility Office Visit	$20 copayment per visit	65% after deductible
Family Planning: Infertility Surgical Treatment	85% after deductible	65% after deductible. Covered for testing and diagnosis only, no coverage for surgical procedures.
Family Planning: Sterilization Tubal Ligation	85% after deductible	65% after deductible
Family Planning: Sterilization Vasectomy	85% after deductible	65% after deductible
Gynecological Exam	$20 copayment per visit; one well-woman exam per calendar year	65% after deductible for illness and injury only. Well-woman exam and related expenses are not covered.

	In-Network*	Out-of-Network**
Home Health Care (Includes necessary services and supplies and billed by home health care agency)	85% after deductible	65% after deductible
Hospice Care:		
Inpatient Facility	85% after deductible	65% after deductible
Outpatient (Maximum of five sessions per week)	85% after deductible	65% after deductible
Inpatient Hospital Service (Includes semiprivate room and board, ancillary hospital charges, diagnostic and therapeutic lab and X-ray services, drugs and medication, hemodialysis, intensive cardiac care, internal prosthetics, newborn delivery, operating and recovery room, preadmission testing, rehabilitative services)	85% after deductible, no copayment, and no reasonable limit on charges billed by the facility; precertification of hospitalization and continued stay required	65% after deductible if the hospitalization and continued stay is precertified
Inpatient Professional Services (*e.g.* physician services, surgeon, assistant surgeon, and anesthesiologist)	85% after deductible	65% after deductible
Lab/X-ray (Outpatient)	85% after deductible	65% after deductible
Mammogram	$20 copayment. If age 35 and over, one exam per calendar year (more frequently if necessary).	65% after deductible. If age 35-39, maximum one exam; if age 40-49, maximum one exam every 24 months; if age 50+, maximum one exam every 12 months (more frequently if necessary).
Maternity—Obstetrician Services	$20 copayment for initial visit. No copayment for subsequent services including prenatal visits, delivery, and postnatal visits.	65% after deductible

	In-Network*	Out-of-Network**
Other Outpatient Services (*e.g.* chemotherapy and radiation treatment)	85% after deductible; no reasonable limit when billed by a facility other than a physician's office	65% after deductible
Outpatient Hospital Services (*e.g.* hemodialysis and preadmission testing)	85% after deductible; no reasonable limit when billed by a network facility	65% after copayment
Outpatient Short-Term Rehabilitation (Includes occupational therapy, physical therapy, and speech therapy)	85% after deductible. Subject to annual maximum of 60 sessions (outpatient) (combined in-and out-of-network)	65% after deductible. Subject to a annual maximum of 60 sessions (outpatient) (combined in- and out-of-network).
Outpatient Specialty Physician Services	$20 copayment per visit	65% after deductible
Outpatient Surgical Services (Includes operating and recovery room, services, and supplies)	85% after deductible; no reasonable limit when billed by a network facility	65% after deductible
Primary Care Physician (Includes adult medical care, adult physical exams, child medical care, routine immunizations and injections, vision and hearing screening, well-child and well-baby care)	$20 copayment per visit	65% after deductible for injury or illness only. Routine physical exams, immunizations, or well-child and well-baby care are not included.
Skilled Nursing Facility	85% after deductible; no reasonable limit on charges billed by a network facility	65% after deductible
Treatment for TMJ	Medical treatment only 85% after deductible	Medical treatment only 65% after deductible
Mental Health/ Substance Abuse Treatment-Inpatient Inpatient Treatment must be precertified to receive benefits Covered expenses include those billed by the treatment facility, including residential treatment, halfway houses, group homes and day hospital treatment programs	85% of covered charges after you meet the deductible	65% after deductible

	In-Network*	Out-of-Network**
Mental Health/ Substance Abuse Treatment-Outpatient Outpatient Treatment must be precertified to receive benefits Covered expenses include those billed by the treatment facility, including residential treatment, halfway houses, group homes and day hospital treatment programs	$20 copay/visit	65% up to 20 visits/year
Maximum Lifetime Benefit	No limit	$500,000

* In-Network benefits are subject to the applicable copay, then covered 100% up to day/visit limits, as applicable. Copays do not count toward meeting deductibles and out-of-pocket maximums.

** Out-of-Network benefits are subject to reasonable and customary (R&C) limits.

*** These amounts also apply to individuals who become eligible for LTD benefits from CNH and those individuals who were hired prior to May 14, 1998 and retire on or after December 1, 2004 and their surviving spouses and eligible dependents.

Non-Network Medical Plan

Where no Network Medical Plan is available, or for Retirees (and their surviving spouses) who retired on or after December 1, 2004 and are Medicare eligible, or for LTD participants who are Medicare eligible, health care is provided through the Non-Network Medical Plan summarized below.

Annual Deductible	$250 per person $500 per family
Annual Out-of-Pocket Maximum (Includes deductible)	
Base pay under $40,000*	$1,500 per person/$3,000 per family
Base pay $40,000-$59,999	$2,000 per person/$4,000 per family
Base pay $60,000-$79,999	$2,500 per person/$5,000 per family
Base pay $80,000 or higher	$3,000 per person/$6,000 per family
Note: All coverage is based on reasonable and customary charges for the services rendered.	
Allergy Tests and Treatments	80% after deductible
Ambulance	80% after deductible
Chiropractic (Medically Necessary)	80% after deductible ($300 calendar year maximum)

Durable Medical Equipment Including Necessary Replacement or Repairs (Crutches, wheelchairs, hospital bed, respirator— including oxygen and other gases—and their administration) (includes one hearing aid per 36 months)	80% after deductible. Subject to a calendar year maximum of $2,500.
Consumable Medical Supplies (*e.g.* Ostomy supplies, catheters, etc.)	80% after deductible
Emergency Care	80% after deductible; if admitted to hospital, must certify within 48 hours
Emergency Care (Physician's office)	80% after deductible
External Prosthetic Devices (Including necessary replacement)	80% after deductible. Subject to a calendar year maximum of $3,000.
Hospice Care: Outpatient (Maximum of five sessions per week)	80% after deductible; precertification required; must meet definition of hospice
Inpatient Hospital Service (Includes semiprivate room and board, ancillary hospital charges, diagnostic and therapeutic lab and X-ray services, drugs and medication, hemodialysis, intensive cardiac care, internal prosthetics, newborn delivery, operating and recovery room, preadmission testing, rehabilitative services)	80% after deductible; the hospitalization and continued stay must be precertified
Inpatient Professional Services (*e.g.* physician services, surgeon, assistant surgeon, and anesthesiologist)	80% after deductible if not billed by hospital
Lab/X-ray (Outpatient)	80% after deductible
Mammogram	100% for well exams. If age 35-39, maximum one exam; if age 40-49, maximum one exam every 24 months; if age 50+, maximum one exam every 12 months (more frequently if necessary); 80% after deductible for treatment of illness or injury
Other Outpatient Services (*e.g.* chemotherapy and radiation treatment)	80% after deductible
Outpatient Hospital Services (*e.g.* hemodialysis and preadmission testing)	80% after deductible

Outpatient Short-Term Rehabilitation (Physical therapy, speech therapy, occupational therapy)	80% after deductible; annual maximum of 60 sessions
Outpatient Surgical Services (Includes operating and recovery room, services, and supplies)	80% after deductible
Pap Smear	100% for well exams; one exam per year if 18 years old or older; 80% after deductible for treatment of illness or injury
Routine Physical	Not covered
Immunizations	100% no deductible
Outpatient Doctor's Office Visits	80% after deductible
Skilled Nursing Facility	80% after deductible
Mental Health/Substance Abuse Treatment (Includes inpatient and outpatient treatment)	Treatment must be precertified to receive benefits. Inpatient - 80% after deductible. Outpatient - 80% after deductible; maximum 30 visits per year.
Maximum Lifetime Benefit	$1,000,000

* These amounts also apply to individuals who become eligible for LTD benefits from CNH and those individuals who were hired prior to May 14, 1998 and retire on or after December 1, 2004 and their surviving spouses and eligible dependents.

** Effective January 1, 2007, prescription coverage is eliminated for all Retirees, surviving spouses of Retirees and LTD participants and/or their covered dependents who are or become eligible for Medicare.

Additional Plan Provisions—Network and Non-Network Medical Plans

1. Home Health Care

The Plan provides continued care and treatment of an individual, normally within seven days following hospitalization for the same or related conditions for which hospitalized (subject to applicable plan limits).

The following home health care services are provided under the program:

(a) Nursing Care

Embodies all medically necessary nursing care which may be readily provided within the patient's home as part of the total physician-directed, prescribed plan of treatment. It

includes coordinating the patient's health care program by evaluating and channeling appropriate information to other participants of the health care team, administering medication, assisting with rehabilitative or terminal care, instructing and guiding the patient and family in procedures resulting in greater self-sufficiency, and other essential nursing services and professional care of the degree of intensity provided for by the Program. Examples of these services would be changing dressings, administering injections, teaching self-administration of insulin and other injectables, evaluating the patient's condition and advising the patient's personal physician of the patient's progress within the treatment plan.

(b) Physical Therapy

Includes all therapy deemed essential to the treatment of the patient when determined and prescribed by the attending physician and the home care agency. Emphasis is on the restorative and rehabilitative services which may easily be provided within the patient's home, making the patient more self-sufficient. This includes implementing, teaching, evaluating and supervising, and when necessary, it also includes exercise regimens for strengthening and maintaining muscles, gait training, prosthetic device training and instructing a responsible family participant in routine exercises to maintain the patient's strength and range of motion.

(c) Occupational Therapy

Occasionally, if appropriate, an occupational therapist may provide therapy services such as evaluating the vocational possibilities of the patient, teaching household activities commensurate with the disability, teaching substitution for nonfunctioning parts of the body, or stimulating the patient's interest in purposeful activity.

(d) Speech Therapy

Speech therapy consists primarily of correcting or restoring the patient's vocal pattern following illness or injury.

(e) Social Services Guidance

Focus is on evaluating the personal, emotional, social and environmental circumstances related to or resulting from the patient's illness and correcting those factors which may further complicate or hinder favorable responses to medical treatment, as requested and directed by the patient's personal physician.

(f) Dietary Guidance

Includes evaluation and recommendations relevant to diet regulations and menu preparations for the patient by nutritionists and dieticians and instructing the patient and/or a responsible family participant to understand the dietary and nutritional requirements within the medical treatment plan.

(g) Home Health Aide Service

This service is intended for patients whose families are unable to provide this service for them and is provided only if the agency determines that the particular patient could not be on home care without such service. A home health aide must be in the employ of the home care agency and have received special training in the care of the sick. The aide gives nonprofessional care to the patient as is necessary when performed upon medical recommendation and under appropriate supervision of the home care nurse. Duties may include such personal care as feeding the patient, helping the patient in and out of bed, meal preparation, getting the children off to school, and various other patient related duties. Benefits are payable only when the service is performed in conjunction with professional service. Eight hours of home health aide service, either fragmented or continuous, constitutes one home care visit. Services provided by or secured by the family or another local social agency are not benefits.

(h) Medical supplies, drugs, and laboratory and X-ray services.

The home health care must be provided by a registered nurse or a state-certified home health care aide under a registered nurse's supervision; or by a social worker, nutritionist, or dietician under the supervision of the personal care physician ("PCP").

The PCP or other attending physician must certify the necessity for the care and the administrator must approve the care. The care will not be covered if:

- Provided by a person who ordinarily resides in the home or by an immediate family participant.
- Consists of transportation services.
- Required certification and/or approval have not been obtained.
- The care is not included in an approved home health care program.

2. Hospice Care

The Plan provides physical, psychological, social, and spiritual care for dying persons with six months or less to live, and for their families.

Hospice benefits services are provided by physician-supervised professionals and volunteers. Hospice services are available in the home. Home care is available on a part-time, intermittent, regularly scheduled, and around-the-clock on call basis. Bereavement services are available to the family. The following categories of care will be provided (subject to applicable plan limits):

(a) Nursing care provided by or under the supervision of a registered nurse;

(b) Medical social services provided by a social worker under the direction of a physician;

(c) Physician services;

(d) Counseling services provided to the patient, family participants, and/or other persons caring for the patient at home;

(e) General inpatient care provided in a hospice inpatient unit;

(f) Medical appliances and supplies;

(g) Physical, occupational, and speech therapies;

(h) Continuous home care provided during periods of crisis as necessary to maintain the patient at home;

(i) Respite care;

(j) Bereavement counseling;

(k) Care required in a nursing home with hospice support; and

(l) Home health aide services.

The PCP or other attending physician must certify that the individual is expected to die within six months. The administrator must approve the hospice program of care based on patient and family need.

Women's Health and Cancer Rights Act of 1998
Under federal law, the Medical Plan is required to provide certain benefits related to breast reconstruction. If you are receiving mastectomy benefits from the medical plan and elect breast reconstruction in connection with a mastectomy, the Plan will cover:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage will be provided in a manner determined in consultation between you and your attending physician. This coverage is subject to the same deductibles and coinsurance limitations that apply for other benefits under the Medical Plan.

Newborns' and Mothers' Health Protection Act of 1996
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under

federal law, require that a provider obtain authorization from the Plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Customer Services
Customer Services is your information line.

When you call Customer Services, you talk to a trained representative responsible for your plan. That phone number is on your Medical identification (ID) card.

Customer Services will:

- Provide information about your plan benefits;
- Address concerns you may have about the network or its providers, if applicable;
- Give you information about network providers in your area, including new physicians and specialists;
- Replace a lost or stolen ID card;
- Certify your hospital admission;
- Provide claim forms if necessary; and
- Provide information about providers in other network locations for dependents living away from home or while traveling.

Identification Cards
You and each dependent receive an ID card.

You should carry this card at all times. Do not loan your ID card to anyone.

If you lose your ID card:
Call Customer Services.

Choosing Access to Treatment
How you receive benefits depends on where you obtain treatment.

Participating in the network is like participating in two plans at once. You may freely move in and out of the network at any time.

You receive a higher level of benefits when you obtain treatment in the network. But your choice of physicians and hospitals is usually limited to those in the network.

On the other hand, you receive a lower level of benefits when you obtain treatment out of the network—but you can be treated by any provider you choose.

So you choose: *higher* benefits if you select treatment in the network or *lower* benefits if you select treatment out of the network.

CNH makes no representation regarding the quality of services provided and is not responsible for the care provided by the provider you choose.

Covered Expense
For an expense to be covered by the Plan, it must be:

- Incurred under the direction of a physician;
- Necessary for the treatment of an injury or sickness;
- Not specifically excluded or otherwise limited under the Plan;
- Not in excess of any specified maximums;
- Reasonable (for out-of-network expenses).

"Necessary" and "Reasonable" are defined in the "Medical Definitions" section.

Annual Deductible
Each dependent enrolled in the Plan must meet a separate per person deductible each year based upon the applicable Network or Non-Network Plan. Two or more covered dependents may help the family meet the family deductible.

The deductible starts over each January 1. There is no carryover from year to year.

An expense must be covered by the Plan to be credited to your deductible.

If two or more dependents are injured in the same accident:

- The family must meet only one per person deductible for all the covered dependents who were in the accident.

Copayments
You make a payment each time you receive treatment (usually $20 for physician's services) in the network. You pay significantly more if you receive treatment out of the network.

Annual Out-of-Pocket Maximum
The annual out-of-pocket maximum limits the amount you pay for your share of covered expenses, including deductibles. The annual out-of-pocket maximum is set each year based on your base pay rate the preceding December.

After you reach the out-of-pocket maximum, the Plan will pay the remaining covered expenses at the applicable percentage for that year, including deductibles.

Each dependent enrolled in the Plan must meet a separate per person out-of-pocket maximum each year, as shown in the applicable schedule above. Two or more covered dependents may help the family meet a family out-of-pocket maximum, if applicable.

The out-of-pocket maximum starts over each January 1. There is no carryover from year to year. The out-of-pocket provision does not apply to prescription drug expenses.

Lifetime Maximum

Network Plan (Out-of-Network Services)—$500,000 per person.

The lifetime maximum does not apply to treatment in the network.

Non-Network Plan—$1,000,000 per person.

Hospital Precertification
This program is designed to involve you and your physician in controlling health care costs under the Network and Non-Network Plan. Please see below for the special precertification process for Mental Health and Substance Abuse Treatment.

Precertification is a confirmation of the benefits the Plan will pay when you are admitted to a hospital.

- You must precertify inpatient hospital admissions to receive a regular benefit reimbursement from the Plan.

- **Non-Emergency Hospitalization:** You must precertify before being admitted.

- **Emergency Hospitalization:** In an emergency, if the problem is life-threatening, you should go to the hospital, as precertification is not necessary. However, if you are admitted to the hospital, you or your doctor must certify within 48 hours after the admission.

- If you do not have a hospital admission precertified, your benefit will be reduced $1,000 or the coinsurance will be reduced 100%, whichever is less. This cannot be applied to the annual deductible or out-of-pocket maximum. However, the copayment will not be applied for emergency confinements where the patient's condition precludes informing the hospital that certification is necessary (*i.e.* unconscious, severe accident, no identification).

Steps to Precertify

If you are admitted to a hospital, you should precertify before the scheduled admission date.

You should allow at least seven days for your precertification to be processed.

If the admission is for the delivery of a baby, certify at any time during the pregnancy, provide the due date, and then notify the precertification administrator within 48 hours after the mother is admitted. A medical counselor will work with the physician and hospital to certify the stay for benefit coverage and handle discharge planning.

If you are admitted to an out-of-network hospital by an out-of-network physician, you should precertify before the scheduled admission date.

Contact the precertification administrator as soon as possible after you are admitted to an out-of-network hospital in an emergency situation.

Provide the following information to the precertification administrator:

- Patient's name and birth date;
- Employee's name and Participant ID or Social Security number;
- Planned admission or surgery date;
- Physician's name, phone number, and address;
- Hospital name, phone number, and address; and
- Reason for admission or procedure.

You, your physician, and the hospital will be notified when an admission has been authorized for benefits.

If the hospitalization is authorized, the precertification administrator will certify the length of stay.

Then, if you elect to remain in the hospital beyond this established length of stay, you or your representative must contact the precertification administrator to request authorization for benefits to continue.

If the admission is not confirmed as necessary, the administrator's physician will review the case with your physician.

If the hospitalization is not authorized for benefits, you may file an appeal with the precertification administrator if you do not agree with its decision.

Substance Abuse and Mental Health Care Precertification

In order to be eligible for any benefit coverage for mental health or substance abuse conditions, you or your dependent must call the precertification telephone number on your medical ID card prior to any treatment.

The precertification administrator will assist you in assessing the situation and ensuring quality care.

In case of emergency, which is defined in the "Mental Health and Substance Abuse Treatment" section below, requiring inpatient treatment, you must contact the precertification administrator within 24 hours of hospital admission to assure that treatment will be covered.

If the precertification administrator is not contacted as specified, no benefits are available under this Plan. If the precertification administrator is contacted, but you elect not to use network benefits and follow the precertification administrator's recommendations, your benefits will be subject to a higher deductible and will be reduced to 65%.

Preexisting Conditions
Preexisting condition restrictions do not apply if you are covered by the plan.

Medical Network: Special Situations
Certain features of network coverage may or may not affect you. You should read this section to know if it applies to your particular situation.

Urgent Care In the Network Service Area
An urgent situation is not life threatening, but requires immediate medical attention—such as a sprain, bone break, fever, sore throat, or minor burns.

You should consult a network pediatrician for guidelines for children under six months of age.

You will receive in-network benefits for urgent care from any licensed physician or urgent care facility by following these steps:

If possible, contact Customer Services before the patient goes to the facility.
This will ensure you receive in-network benefits. If you cannot contact Customer Services before you go to the facility, contact them within 48 hours after your treatment.

Use a network provider to receive in-network benefits. If outside your normal care area, contact Customer Services to locate a network provider.

The administrator's Medical Director will determine whether the treatment was urgent and qualifies for in-network coverage. If the treatment was urgent, charges will be reimbursed at the in-network benefit level less the applicable copayment. You will be eligible for out-of-network coverage if in-network benefits do not apply.

You should receive follow-up care when you return home.

If there is an urgent need for follow-up care, contact Customer Services to request authorization in advance.

If you are admitted to the hospital, call the precertification administrator within 48 hours and follow the representative's instructions to make sure you receive the in-network level of benefits.

Emergency Care In the Network Service Area
An emergency is a life-threatening illness, or an injury that requires immediate medical attention. Apparent heart attacks, severe bleeding, loss of consciousness, and severe or multiple injuries are all examples of emergencies.

If possible, contact Customer Services before you go to the emergency facility.

This will ensure you receive in-network benefits. If you cannot contact Customer Services before you go to the emergency facility, contact them within 48 hours after your emergency treatment whether or not you are hospitalized.

Ask for an itemized bill and receipt marked clearly as "Emergency Services." Call Customer Services for instructions on how to receive reimbursement.

The administrator's Medical Director will review the emergency treatment and determine if it qualifies for in-network coverage. If the treatment was due to an emergency, your charges will be reimbursed at the in-network benefit level less the applicable copayment. You will be eligible for out-of-network coverage if in-network benefits do not apply, and you must file a claim form for reimbursement.

Emergency Hospital Admission In the Network Service Area
Call to precertify admission to an out-of-network hospital.

If you choose to stay in the out-of-network hospital rather than be transferred, you must obtain authorization for out-of-network coverage. You must call Customer Services at the telephone number on the back of your ID card. If you do not call for authorization, your share of covered expenses will be 100% of covered hospital expenses up to $1,000 (maximum penalty).

Urgent or Emergency Care Out of the Network Area
For emergency or non-emergency treatment, you must contact Customer Services at the number listed on your ID card.

Customer Services will tell you if a Medical Network is available in the area in which you are traveling. If so, you must go to a network provider to receive in-network benefits.

If a network is not available, and you need immediate care, go to any physician.
Pay the usual fee and submit the bill to Customer Services. Contact Customer Services within 48 hours of receiving the care. If Customer Services confirms that you need immediate medical attention, you will receive in-network benefits. If not, your expenses will be processed for out-of-network benefits.

Guest Privileges
Your covered dependent may receive in-network benefits by using the providers in the travel network if:

- You live in a PPO Network area;
- You are enrolled in the Network Plan;

- Your dependent lives outside your home PPO Network service area and will be living in that area for at least 90 days; and
- You or your dependent receives treatment from a provider in the travel network.
- No special application is necessary.

Transitional Care

Transitional care will be available to individuals who at the time of initial entry into the Network Plan suffer from a medical condition for which the maintenance of the current attending physician is necessary for the well-being of the patient. The patient may continue to utilize the attending physician for the specific condition for a specific limited period of time and receive in-network benefits. The types of conditions which would fall into this category would be acute cases where there is a specified end date to the course of treatment. This would include, but is not limited to, certain types of post operative care, radiation therapy, chemotherapy, pregnancy, terminal conditions where life expectancy is 12 months or less, etc. The Network Administrator will be responsible for reviewing transitional care requests. In the event a dispute exists regarding the applicability of transitional care, a mutually agreeable third party physician will determine this applicability.

Network and Non-Network Medical Plans: Expenses Not Covered

- Acupuncture therapy.
- Artificial aids, such as:
  - — Arch supports;
  - — Contact lenses;
  - — Corrective orthopedic shoes;
  - — Dentures;
  - — Over-the-counter elastic stockings, garter belts, and corsets;
  - — Eyeglass lenses and frames; and
  - — Wigs (except the Plan will cover one wig per lifetime following chemotherapy, and one wig each 36 months for individuals diagnosed with alopecia).
- Medication or devices utilized for the prevention of pregnancy.
- Any treatment of teeth, gums or any oral surgery, unless it is the result of an accident, or is due to a covered medical condition.
- Custodial care.
- Education therapy for learning disabilities.
- Fees for replaced blood or blood product.
- In-vitro fertilization.

- Artificial means of conception.
- Normal cosmetic therapy or surgery (and any complications thereof).
- Obesity control programs.
- Organ donation fees paid for a donated organ.
- Personal or comfort items.
- Private room or private-duty nurse (unless Necessary).
- Reversal of voluntary sterilization.
- Routine foot care (except approved orthotics).
- "Take-home" prescription drugs and over-the-counter drugs.
- In-network routine physical exams more than once per year.
- Transsexual surgery.
- Vocational rehabilitation.
- In connection with any eye exam and the purchase and fitting of eyeglasses and contact lenses; however, benefits will be payable for eyeglasses if they are prescribed as a direct result of: an injury which affects vision; a condition where the lens system of the eye has been destroyed; or, treatment of strabismus.
- In connection with cosmetic surgery or any complications thereof (meaning plastic surgery, reconstructive surgery, or cosmetic surgery which improves, alters, or enhances appearance, whether or not for psychological or emotional reasons) except to the extent Necessary to:
  - — Improve the function of a part of the body (other than a tooth or structure that supports the teeth) that is malformed:
    - – As the result of a severe birth defect (including harelip or webbed fingers or toes); or
    - – As a direct result of disease or surgery performed to treat a disease or injury.
  - — Repair an injury in the calendar year of the accident which causes the injury or in the next calendar year.

In addition, treatments, services or supplies are not covered if they are:

- Not recommended and approved by a physician.
- In connection with services rendered by an immediate family participant.
- Not necessary as determined by the administrator for the treatment of the injury or illness.
- In excess of the reasonable charge for the services performed or the material furnished, as determined by the administrator.
- For health or check-up examinations, unless related to medical treatment for an injury or illness or except as expressly provided by plan provisions.
- Resulting from the treatment of:
  - — Weak, strained or flat feet;
  - — Instability or imbalance of the foot; or
  - — Any tarsalgia, metatarsalgia or bunion, except surgery involving the cutting and suturing of tendons, ligaments and bones.
- Resulting from the treatment of toenails or superficial lesions of the foot including corns, calluses and warts, except for the removal of the nail root or matrix or the first palliative treatment of corns and calluses.
- In connection with food supplements, minerals, vitamins or drugs that can be purchased without a written prescription (outpatient).
- In connection with speech therapy except to restore speech lost as a result of an accident or injury.
- Education or training procedures for speech, hearing or vision.
- Smoking cessation programs and treatment.
- Incurred by a dependent child, retired employee or survivor who becomes entitled to plan benefits as an employee.
- In connection with procedures, services, drugs and other supplies that are, as determined by the administrator, experimental or still under clinical investigation by health professionals.
- Related to therapy, supplies or counseling for sexual dysfunctions or inadequacies.
- Related to sex change surgery or any treatment of gender identity disorders.

- Related to or in conjunction with the following counseling services: marriage, family, child, career, social adjustment, pastoral or financial.

- In a hospital where there would be no charges made if coverage were not in force (*e.g.*, in a federal, state or local government operated facility).

- For accidental bodily injury arising out of or in the course of employment or where such treatment is payable under any workers' compensation or occupational disease act or law.

- Resulting from injury or illness compensable under any law of government for its own civilian employees and their dependents except as permitted under the Coordination of Benefits rules.

- Resulting from injury or illness caused by war, declared or undeclared, by any act of war, by service in the armed forces of any country or any civilian noncombatant unit serving with such forces or by participation in a riot.

- Resulting from participation in or attempt to commit an assault or felony.

Mental Health and Substance Abuse Treatment

Covered Services
Covered Services for purposes of this benefit mean the Medically Necessary Mental Health or Substance Abuse Care covered under this program, except to the extent that such care is otherwise limited or excluded under this program or the Plan. You must certify that treatment or proposed treatment is covered in accordance with this program and this Plan from the precertification administrator before benefits are payable under this program.

Medically Necessary, for purposes of this benefit, means a service or supply which the administrator has established for benefits determination purposes to be:

- Provided for and consistent with the symptoms or proper diagnoses and treatment for the specific participant's illness, disease or condition;

- Not primarily for the convenience of the participant, the participant's family or the provider providing the service; and

- The approximate Level of Care that can safely be provided for the specific participant's diagnosed condition in accordance with both generally accepted psychiatric and mental health practices and the professional and technical standards adopted by the administrator.

Mental Health or Substance Abuse Care means the Medically Necessary care provided by an eligible provider for the treatment of a mental health or behavioral illness or condition or a substance abuse or chemical dependency illness or condition that the administrator has determined:

- Is a clinically significant behavioral or psychological syndrome or pattern;

- Is associated with a painful symptom, or
- Substantially or materially impairs a person's ability to function in one or more major life activities; and
- Is recognized by the American Psychiatric Association as a mental health or behavioral illness or condition.

Level of Care means the intensity and/or magnitude of a Mental Health or Substance Abuse Care treatment setting, treatment plan or treatment modality including but not limited to:

- Acute care facilities;
- Less intensive inpatient or outpatient alternatives to acute care facilities, such as residential treatment centers, group home or structured outpatient programs;
- Outpatient visits; or
- Medication management.

For purposes of this benefit, an emergency or emergency condition is a Mental Health or Substance Abuse condition determined by the administrator to require immediate medical diagnosis, attention or treatment in order to avoid a situation which could reasonably be expected to:

- Cause the participant or another person harm; or
- Jeopardize the participant's life or cause the participant to jeopardize the life of another person.

Mental Health and Substance Abuse: Exclusions and Limitations
Expenses you have for mental health and substance abuse treatment, either in- or out-of-network, do not count toward any medical plan deductibles or out-of-pocket limits.

Covered services do not include any of the following:

- Custodial care, educational rehabilitation, or treatment of learning disabilities, regardless of the setting in which such services are provided;
- State hospital treatment except when determined by the administrator to be Medically Necessary;
- Treatment for personal or professional growth, development, or training or professional certification;
- Evaluation, consultation or therapy for educational or professional training, or for investigational purposes relating to employment;

- Psychiatric or psychological examinations, testing, or treatments that the administrator determines are not Medically Necessary, but which nevertheless may be required for purposes of obtaining or maintaining employment or insurance or pursuant to judicial or administrative proceedings;

- Academic education during residential treatment;

- Therapies which do not meet national standards for mental health professional practice; for example, Erhard/The Forum, primal therapy, bioenergetics therapy, crystal healing therapy;

- Experimental or investigational therapies;

- Court ordered psychiatric or substance abuse treatment unless the administrator determines that such services are Medically Necessary for the treatment of a condition included in the *Diagnostic and Statistical Manual of Mental Disorder (DSM)*, revised, as amended to the most recent version of *DSM*;

- Psychological testing, except where conducted for purposes of diagnosing a *DSM* mental disorder or when rendered in connection with treatment of such a mental disorder. All such testing requires preauthorization by the administrator;

- Charges for services, supplies, or treatment that are covered charges under the medical portion of this Plan, or other employer sponsored health care plan;

- Prescription drugs, except where dispensed by a hospital, residential, or day treatment program to a covered individual who, at the time of dispensing, is receiving treatment at the appropriate facility or program;

- Private duty nursing;

- Services to treat conditions that are identified by the *DSM* as not being attributable to a mental disorder (*i.e.*, V Codes);

- Treatment of congenital or organic disorders, including, but not limited to organic brain disease, Alzheimer's disease, autism, and mental retardation;

- Marriage counseling, except when rendered in connection with treatment of a *DSM* mental disorder;

- Treatment for smoking cessation, weight reduction, obesity, stammering, or stuttering;

- Inpatient treatment for eating disorders, unless the administrators determines that inpatient treatment is Medically Necessary for the treatment of another *DSM* mental disorder;

- Aversion therapy;

- Treatment for codependency, except when rendered in connection with treatment of a *DSM* mental disorder;

- Nonabstinence based on nutritionally-based, chemical dependency treatment;
- Treatment for sexual addiction;
- Treatment of chronic pain, except when rendered in connection with treatment of a *DSM* mental disorder;
- Treatment or consultations provided via telephone;
- Services, treatment, or supplies provided as a result of any worker's compensation law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state, or of any subdivision thereof; or caused by the conduct or omission of a third-party for which the participant has a claim for damages or relief, unless the participant provides the administrator with a lien against such claim for damages or relief in a form and manner satisfactory to the administrator.
- Treatment or consultations provided by the participant's parents, siblings, children, current or former spouse, or domiciliary partner; and
- Treatment for stress, except when rendered in connection with treatment of a *DSM* mental disorder.

Prescription Drugs
(Eligible Participants in the Network and Non-Network Medical Plan only.)

Prescription Drugs	Coverage	Where to Purchase
Annual Deductible	Employees hired on or after May 2, 2004 only. $50 per person	
Coinsurance	Employees hired on or after May 2, 2004 only: Plan pays 70% of covered charges after deductible, subject to participant minimums/maximums below.	

Prescription Drugs	Coverage	Where to Purchase
Short-term Prescription (30-day supply or less)	Employees hired on or after May 2, 2004: • Generic: $5 min/$200 max • Formulary: $15 min/$300 max* • Non-Formulary: $30 min/$no max* Employees hired before May 2, 2004: • Generic: $10 • Formulary: $30* • Non-Formulary: $50 * 2007 & 2008, copays will be $10/$35/$55 respectively 2009 – 2011, copays will be $10/$40/$60 respectively	Participating WHI pharmacies
Long-term Prescription (30 to 90 day supply)	Employees hired on or after May 2, 2004: • Generic: $10 min/$400 max • Formulary: $30 min/$600 max* • Non-Formulary: $60 min/no max* Employees hired before May 2, 2004: • Generic: $20 • Formulary: $60* • Non-Formulary: $100 * 2007 & 2008, copays will be $20/$70/$110 respectively 2009 – 2011, copays will be $20/$80/$120 respectively	By mail through Walgreens Health Initiatives
Lifestyle Prescriptions • Smoking cessation • Obesity control • E.D. • Cosmetic treatments • Infertility • Certain contraceptives (abortive, emergency, implantable and injectable) • Diaphragms	Prescriptions for lifestyle drugs are not covered by the plan, but can be obtained at WHI network pharmacies at the full discounted network price.	Participating WHI pharmacies

* Plus cost difference if generic is available.

Note: Prescription deductibles, copays and coinsurance do not apply toward meeting medical deductibles or out-of-pocket maximums.

If you enroll for any medical coverage through the Network Medical Plan or Non-Network Medical Plan, you will automatically be enrolled in prescription drug coverage. **Note: Effective January 1, 2007, prescription drug coverage is eliminated for Retirees, surviving spouses and LTD participants and/or their covered dependents who are, or who become, eligible for Medicare.**

Walgreens Health Initiatives (WHI) administers all of CNH's prescription drug benefits and coordinates its mail-order program through Walgreens Healthcare Plus. You will receive an ID card from WHI after your enrollment. Present your ID card when you go to a participating pharmacy.

Retail Pharmacies
When you need a prescription drug for a 30-day supply or less, take your prescription to a participating WHI network pharmacy. You will be subject to the specific plan provisions detailed in the schedule of benefit chart above.

Participating WHI pharmacies include most, but not all, locations of the following:

- Osco;
- Walgreens;
- CVS;
- Kmart;
- Wal-Mart; and
- Many independent pharmacies.

When you receive your WHI ID card in the mail, you will receive a directory of participating pharmacies in your area. Also, you can call the 800 number on your ID card and ask for a list of participating pharmacies in your area.

In order for your prescription drugs to be covered, you must either have your prescription filled at a participating network pharmacy (for 30-day supply or less), or use Walgreens Health Initiatives mail-order pharmacy (greater than a 30-day supply). *If you have a prescription filled any other way, it will not be covered by this plan.*

Mail-Order Prescriptions
To obtain prescriptions for greater than a 30-day, but up to a 90-day supply, use the mail-order prescription drug program.

The program is provided by Walgreens Health Initiatives.

Prescriptions Requiring Prior Authorization for Benefits
Prior authorization is required by WHI to determine whether the following drugs will be approved for coverage:

- Betaseron;
- Fertility agents;
- Growth hormones; and
- Products used for cosmetic purposes, which are being considered for medical reasons.

In most cases, authorization can be handled by phone. Your physician should call 1-877-665-6609. If additional documentation is required, your physician will be instructed where to send a letter documenting the necessity for treating a covered health condition with such drug.

Prescription Drug Expenses Not Covered: Exclusions

- Any devices or appliances, such as orthotics, and other nonmedical substances;
- Any vaccine administered for the prevention of infectious diseases;
- Antineoplastic agents except in oral dosage form;
- Any medication administered and entirely consumed in connection with care rendered in the home and office;
- Any charge for administration of covered drugs;
- Any covered drug in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician's order;
- More than a 30-day supply of a covered drug from a retail pharmacy;
- Any syringes and needles, except for disposable insulin syringes and needles prescribed with injectable insulin;
- Any drug requiring a prescription by state law, but not federal law;
- Drugs for which the WHI ingredient cost plus the dispensing fee is either equal to or less than the copayment amount;
- Medications furnished on an inpatient or outpatient basis covered under any other plan providing group coverage for prescription drugs or insulin through a coordination of benefits provision, such as major medical, home health care benefits, or outpatient benefits;

- Excess retail costs charged by a WHI participating network pharmacy in the event it was not informed of your WHI coverage; and

- Over-the-counter products are not covered unless specifically included, such as insulin.

For information on how health plan benefits coordinate with other plans, see the "Coordination of Benefits" section of this handbook.

Conversion
If your coverage ends, you and your covered dependents may be eligible to convert to an individual health insurance policy. The policy will be a type offered by the claims administrator for group conversions at the time you apply. It will offer benefits in line with any law or regulation which applies. Conversion policies may not be written in some states.

You must provide written application, on the proper form, along with the initial premium payment to the claims administrator within 30 days after the date your coverage terminates.

Contact the claims administrator for additional information.

Definitions
Alcohol or Other Drug Dependency Treatment Center
A facility which provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a physician and also is:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral;

- Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; and

- Licensed, certified, or approved as an alcohol or other drug dependency treatment center by any state agency having legal authority to so license, certify, or approve.

Ambulatory Surgical Center
Any public or private establishment which:

- Has an organized staff of medical physicians;

- Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

- Has continuous physician services and registered professional nursing services whenever a patient is in the facility;

- Does not provide services or other accommodations for patients to stay overnight; and

- Is certified by the claims administrator or the contracted network.

Convalescent Facility
An institution (or distinct part of an institution) which:

- Is primarily engaged in and licensed to provide on the premises and for compensation from its patients, skilled nursing services and physical rehabilitation services to convalescing patients;
- Provides these services under the full-time supervision of an M.D., D.O., or R.N.;
- Maintains a complete medical record on each patient;
- Is not other than incidentally a place for rest, for custodial care, for educational care, for the aged, drug addicts, alcoholics, or individuals who are mentally retarded or have mental disorders;
- Has a written personal treatment plan for each patient which is prescribed and supervised by an M.D. or D.O., includes a diagnostic assessment of the patient and a description of the treatment rendered, and provides for follow-up assessments by or under the direction of the supervising M.D. or D.O.;
- Provides an ongoing quality assurance program which includes reviews by M.D.s or D.O.s who do not own or direct the facility; and
- A convalescent facility will be treated the same as a hospital as the term used to determine benefits for physician services.

Cosmetic Surgery
Plastic surgery or reconstructive surgery which improves, alters, or enhances appearance, except to the extent needed to:

- Improve the function of a part of the body (other than a tooth or structure that supports the teeth) that is malformed as the result of a severe birth defect (including harelip, webbed fingers or toes) or as a direct result of a disease or surgery performed to treat a disease or injury; or
- Repair an injury in the calendar year of the accident which causes the injury or in the next calendar year.

Covered Expenses
A medical expense incurred under the direction of a physician, which is necessary for the treatment of an injury or sickness, not specifically excluded or otherwise limited under the Plan, not in excess of specified maximums, and is reasonable. This includes expenses for designated preventive diagnostic testing, designated immunizations, and vaccinations.

Custodial Care
Routine services or supplies, including room and board and other institutional services, furnished to assist in daily living. Room and board will not be considered custodial care when combined with skilled nursing services and other necessary therapeutic services and supplies in accordance

with generally accepted medical standards. Such services and supplies must be provided in an institution which is approved by the claims administrator. Any medical treatment program which includes custodial care elements must be reasonably expected to substantially improve the covered person's medical condition in order to be covered.

DRG
Diagnostic Related Groups. Classifications to group inpatient cases by principal diagnosis and other relevant factors. The "DRG Amount" is a predetermined charge for each DRG as determined by applicable law (or regulation) or by the claims administrator.

Home Health Care
A program for continued care and treatment of an individual, normally within seven days following hospitalization, for the same or related conditions for which hospitalized. The necessity of the program must be certified by the attending physician and approved by the claims administrator. Services rendered under the program are skilled nursing care, home health services, paraprofessional nursing care, therapeutic services (physical or speech therapy), medical supplies, drugs, and laboratory and X-ray services. The care must be provided by a registered nurse or a state-certified home health care aide under a registered nurse's supervision. The care will not be covered if:

- Not included in the claims administrator's approved home health care program;
- Provided by a person who ordinarily resides in your home, or by an immediate family member;
- Provided by a social worker; or
- Consists of transportation services.

Hospice
A centrally administered program of palliative and supportive services which provides physical, psychological, social, and spiritual care for dying persons (who have six months or less to live as diagnosed and certified by the attending physician) and their families. Services are provided by a physician-supervised interdisciplinary team of professionals and volunteers. Hospice services are available in the home. Home care is available on a part-time, intermittent, regularly scheduled, and around-the-clock on-call basis. Bereavement services are available to the family. The claims administrator's benefit approval for a hospice program of care is based on patient and family need.

Hospital
An institution which:

- Maintains permanent and full-time facilities for bed care of resident patients;
- Has a physician in regular, full-time attendance;
- Continuously provides 24-hour-a-day nursing service by registered nurses;

- Primarily engages in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics, or a place for drug addicts; and

- Operates lawfully in the jurisdiction in which it is located.

Medicare Allowable Charge
The charge which Medicare considers to be an appropriate reimbursement for charges made by providers other than hospitals.

Necessary
A service or supply is Necessary if it is for the diagnosis, care, or treatment of a physical or mental condition and widely accepted professionally in the U.S. as effective, appropriate, and essential, based upon recognized standards of the health care specialty involved.

The Plan will not consider necessary:

- Services rendered by a health care provider that do not require the technical skills of the provider;

- Services and supplies furnished mainly for personal comfort or convenience of the covered person, anyone who cares for the covered person, or any member of the covered person's family;

- Services and supplies furnished because the covered person is hospitalized on a day when he or she could be diagnosed or treated while not hospitalized; or

- The part of the cost that exceeds that of any other service or supply which would be sufficient to diagnose and treat the physical or mental condition.

Outpatient Preadmission Test
A test performed in anticipation of hospital confinement if:

- The test is related to the problem for which hospitalization is required;

- The test has been ordered by a physician after a condition requiring the confinement has been diagnosed and the hospital admission has been requested; and

- The test is done within seven days prior to the hospital admission.

Physician
- Doctor of Medicine (M.D.);

- Doctor of Osteopathy (D.O.);

- Doctor of Chiropractic (D.C.);

- Doctor of Podiatry (D.P.M. or D.S.C.);
- Doctor of Dentistry (D.D.S. or D.M.D.); and
- Doctor of Optometry (O.D.).

A physician, for purposes of mental health and substance abuse treatment, includes psychiatrist, psychoanalyst, psychologist, or other physician specializing in the treatment of substance abuse or mental health disorders. The physician must be licensed by the state in which the service is provided.

The physician must be licensed to perform a particular service which is covered by the Plan. The physician cannot be a member of a covered person's immediate family.

Prosthesis

- An artificial replacement body part that may be missing or defective as a result of surgical intervention, trauma, disease, or developmental anomaly; or
- A device to aid or augment the performance of natural bodily functions.

Reasonable

The charge for a service or a supply which is the lower of the provider's usual charge or the prevailing charge in the geographic area where it is furnished—as determined by the claims administrator. The claims administrator takes into account the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility, and the prevailing charge in other areas. The DRG amount will be considered the reasonable charge if a hospital or other facility is required by law to charge the DRG amount.

Spinal Manipulative Therapy

Manual manipulation of the spine to restore mobility to the joints and to allow vertebrae to assume their normal position.

Traditional Dental Plan—Section C

Traditional Dental Plan—Section C

The Traditional Dental Plan reimburses covered expenses in four different categories: preventive, basic, major and orthodontia. For basic or major treatment, you must meet an annual per person deductible for covered dental expenses before the plan pays benefits, as described below. For preventive and orthodontia treatment, the plan pays a percentage of benefits with no deductible. Preventive care benefits are paid at 100%.

The Traditional Dental Plan is administered by the claims administrator identified in Section K of this handbook.

Schedule of Benefits

Plan Feature	Traditional Dental Plan*
Deductible	$0 for preventive and orthodontia services $50 per person for basic and major services $150 per family for basic and major services
Annual Maximum	$1,500 per person, combined for preventive, basic and major services
Lifetime Maximum	$5,000 per person for periodontic treatment $1,550 per person for orthodontia
Services	
Preventive – Exams and routine cleanings (or cleanings necessitated by a dental condition)	Plan pays $100%* (no deductible)
Basic – Fillings, extractions and oral surgery, single crowns	Plan pays 80% after deductible
Major – Bridgework and dentures	Plan pays 50% after deductible
Orthodontia – Braces	Plan pays 50%* (no deductible), not to exceed $1,550

* The Traditional Dental Plan reimburses covered services up to the usual and customary charge, which is the going rate charged for a particular service in a particular geographic area. Participants are responsible for paying any amounts over the usual and customary charge.

**The $50 deductible is combined for basic and major services, which means you need to meet this deductible only once in a calendar year before the Plan pays benefits.

Deductible
The annual deductible is the amount of covered expenses that you must pay before the program pays any benefits. You pay an annual deductible only for dental treatment that is considered basic or major, as described below.

Your annual deductible is $50 per person, or a maximum of $150 for a family. The family deductible is combined for all family participants; each individual's covered expenses apply toward the $150 total amount. You may use any combination of basic and major covered expenses to meet the individual or family deductible. When you have met the deductible, you and your covered family participants pay no further deductibles for the rest of the calendar year.

Calendar Year Maximum
The maximum benefit you can receive in a calendar year for any combination of preventive, basic and major treatment is $1,500.

Covered Dental Expenses
Covered dental expenses are the usual and customary charges for eligible services. These services must be performed or prescribed by a dentist and necessary in terms of generally accepted dental standards.

For many services, the Traditional Dental Plan pays a percentage of the "usual and customary" charge. The usual and customary charge is the prevailing rate charged for a procedure, service or supply, taking into account the geographic area in which the services are provided. Some dental offices may charge more than the usual and customary amount for services. Whatever the cost, however, you are responsible for paying amounts above and beyond the percentage of the usual and customary charge reimbursed by the Plan.

Preventive Treatment
You pay nothing for covered preventive care. These services are covered at 100% of the usual and customary charges with no deductible:

- Clinical oral examinations (maximum of two per calendar year).*
- Dental cleaning (prophylaxis) (maximum of two per calendar year; up to two additional cleanings per year if necessitated by a dental condition).*
- Topical application of fluoride (maximum of two treatments per calendar year).*
- Emergency palliative treatment for dental pain.
- Sealants for children up to age 17 (maximum of one treatment per posterior tooth per 36-month period; limited to the occlusal surfaces of permanent molars that are free of decay and restoration).
- Space maintainers to replace prematurely lost teeth for children up to age 19.
- Supplementary bitewing X-rays (maximum of two charges per calendar year).

- Cosmetic bonding of up to 16 teeth per person per lifetime.

  * Benefits for these services are subject to Delta Dental approval. You may have these services performed more often than the Plan allows if your physician or dentist provides adequate evidence of the necessity for additional services with your claim.

Basic Treatment
After you meet the annual deductible, the Plan pays 80% and you pay 20% of usual and customary charges for:

- Simple extractions of teeth.
- Oral surgery.
- Basic restorations (fillings) of carions or broken teeth using silver or resin-based composite filling materials (use of resin-based composite is restricted to specific front teeth only).
- Major restorations of carious or broken teeth using inlays, onlays, gold fillings or crowns, when the teeth cannot be restored by filling materials used in basic restorations.
- Repair or recementing of crowns, inlays, onlays, bridgework or dentures; relining or rebasing dentures more than six months after the installation or replacement of the denture, with a maximum of one charge in any 36-month period.
- General anesthetics administered in connection with covered oral or dental surgery when dentally necessary.
- Endodontic treatment, including root canal therapy.
- Injection of antibiotic drugs by the attending dentist.
- Periodontic treatment (up to $5,000 lifetime maximum).
- Use of anti-inflammatory drugs for oral surgery.

Major Treatment
After you meet the annual deductible, the Plan pays 50% and you pay 50% of the usual and customary charges for the following covered services:

- Installing fixed bridgework (including inlays and crowns as abutments).
- Installing partial or full removable dentures (including precision adjustments and follow-up adjustments during the six months following installation).

Orthodontia Treatment
You do not have to meet a deductible before the Plan provides benefits for orthodontia expenses. The Plan pays 50% and you pay 50% of usual and customary charges for:

- Comprehensive full-banded orthodontic treatment.
- Appliances for tooth guidance (maximum of one appliance per person).
- Appliance to control harmful habits (maximum of one appliance per person).
- Orthodontic retainers (maximum of one appliance per person).

Orthodontic treatment may involve appliances, surgery, functional and myofunctional therapy, and other related treatments to correct the dental irregularities that may result from abnormal growth and development of teeth, gums or jaws or accidental injury.

The Plan pays for orthodontic expenses in installments. The first payment is made when the orthodontic appliance is installed. Additional payments are made monthly. Before making the first payment, Delta Dental allots 25% of the charge for the entire course of treatment to the appliance. The rest of such charge is prorated over the estimated length of treatment.

The maximum lifetime benefit for orthodontic treatment is $1,550 for each covered person.

Exclusions
The following dental services are not covered by the Plan:

- Procedures, services or supplies solely for cosmetic reasons, including charges for the personalization or characterization of a denture.
- Replacement of a lost, misplaced, or stolen prosthetic device or appliance.
- Replacement of a bridge or denture within five years following the date of the original installation, unless the replacement is necessary due to the placement of an original full denture or the extraction of natural teeth; or the bridge or denture has been damaged beyond repair as the result of an accidental injury while you are covered under the Plan.
- Replacement of a bridge or denture that is, or can be made, usable according to common dental standards of functional acceptability.
- Procedures, appliances or restorations, other than full dentures, if the primary purpose is to alter dimension, stabilize periodontally involved teeth or restore occlusion.
- Repair or replacement of an orthodontic appliance.
- Porcelain or acrylic veneers or similar properties of crowns and pontics placed on, or replacing, the upper and lower first, second and third molars.

- Charges made other than by a dentist, or another physician, acting within the scope of his or her license, except for charges for procedures performed by a licensed dental hygienist under the supervision and direction of a legally qualified dentist or physician.

- Services or supplies received as a result of past or present service in the armed forces of a government or under any law of a government, except where the government plan establishes payments or benefits for its civilian employees or their dependents, in which case the program's coordination of benefits rules apply.

- Services from a medical department, clinic or similar facility, provided or maintained by a family participant's employer, unless the individual is legally obligated to pay the charge.

- Charges in excess of usual and customary limits.

- Charges for unnecessary care or treatment.

- Charges for which the employee or dependent is reimbursed by a public program.

- Services rendered by a participant of the employee's immediately family.

- Services or dental work provided on or after the date your coverage terminates.

- Replacement of a lost, misplaced or stolen prosthetic device or appliance.

- Plaque control programs.

- Procedures, services or supplies that do not meet accepted standards of dental practice, including charges for procedures, services and supplies that are experimental.

- Sargenti-type root canal therapy.

- Services or supplies received as a result of dental disease, defect or injury due to war or any act of war (declared or undeclared).

- Counseling or supplies for oral hygiene or dietary instruction.

- Periodontal splinting.

- Charges related to an injury resulting from employment for wage or profit.

- Services related to Temporomandibular Joint Syndrome (TMJ).

- Charges related to a sickness for which the employee or dependent is entitled to benefits from Workers' Compensation or a similar law.

- Implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.

- Charges that the employee or dependent is not legally required to pay, or charges that would not have been made if no dental coverage existed.

- Charges for failing to keep a scheduled appointment, or charges for not completing claim forms.

- Charges in a hospital or dental facility owned or operated by the United States government.

- Charges if payment under the Plan is prohibited by any law of the jurisdiction in which the employee or dependent resides at the time the expense is incurred.

Predetermination of Benefits
CNH provides a predetermination of benefits procedure to alleviate some concerns about the coverage of the cost of your dental treatment.

The predetermination of benefits process is typically used when the anticipated treatment is expected to be expensive (generally over $125). CNH recommends predetermination for services that involve crowns, fixed bridgework and other significant treatment. In these situations, ask your dentist to describe the recommended treatment, estimate the charges and send the information to Delta Dental for review. You and your dentist will receive notice of the benefits payable under the program based on current available benefits, or if additional information is required before a determination can be made.

The dentist should send a revised treatment plan to Delta Dental if there is a major change in the treatment plan. When the treatment is completed, the dentist simply needs to put the service date on the reply sent to his or her office, sign and date it and then return the document to Delta Dental.

Predetermination of benefits is intended to enable the participant and dentist to reasonably and realistically plan treatment. The process provides a reasonable estimate of benefits that would be payable under the program based on facts and circumstances at the time the estimate is requested. The process does not guarantee payment.

The predetermination procedure should not be used for:

- Emergency treatment;

- Routine oral exams;

- X-rays, cleaning, and scaling; and fluoride treatment; or

- Dental services which cost less than $125.

Benefits After Coverage Ends
No benefits will be payable for covered dental expenses incurred by a covered person after the Dental Plan benefits for that person end, even if a predetermination of benefits for dental services

has been approved. However, benefits for covered dental expenses incurred for a covered person for the following services will be paid after Dental Plan benefits end;

- For a prosthetic device if:
  - — The dentist prepared the abutment teeth and made impressions while the Dental Plan benefits for the covered person were in effect; and
  - — The device is installed within 60 days after the date the Dental Plan benefits end; or
- For a crown if:
  - — The dentist prepared the tooth for the crown while the Dental Plan benefits for the covered person were in effect; and
  - — The crown is installed within 60 days after the date the Dental Plan benefits end; or
- For root canal therapy if:
  - — The dentist opened the tooth while the Dental Plan benefits for the covered person were in effect; and
  - — The treatment is finished within 60 days after the date the Dental Plan benefits end.

Vision Plan—Section D

Vision Plan—Section D

This vision coverage is administered through the claims administrator identified in Section K of this handbook. The administrator has developed a nationwide network of vision care professionals. You can choose to use this network by going to a network doctor, or you can be reimbursed in part for getting your routine eye care from a doctor who is not a member of the network.

If you use the network, covered services are prepaid with no deductible. If you use the services of a doctor who is not a participant in the network, the program reimburses you for covered expenses according to a schedule of benefits.

What the Program Covers
Through the network, participating doctors agree to perform services at agreed-upon fees. If you use any other doctor, the program pays a portion of the cost based on a schedule of fees for certain covered services.

Network Providers
If you choose treatment by a network doctor, the program pays:

- 100% for an annual routine eye examination.
- 100% each year for lenses, including single vision, bifocal, and trifocal lenses as well as tinted and photochromic lenses. If the doctor prescribes other, more complex and expensive lenses that are Medically Necessary, they are covered in full.
- 100% each year for most frames. The program offers a wide choice of frames. You pay the difference between the wholesale price of the standard frames and the wholesale price of the optional frames.
- 100% each year for contact lenses medically necessary* for any of these conditions:
  - — Following cataract surgery;
  - — To correct extreme vision problems that cannot be corrected by eyeglasses;
  - — Certain conditions of anisometropia; and
  - — Keratoconus.
- $150 total for an eye exam and contact lenses that are not medically necessary*.

* "Medically necessary" for this purpose means your vision cannot be corrected with eyeglasses.

If you get contacts, any eyeglasses you purchase will not be covered that calendar year.

Out of Network
Instead of going to a network provider, you can be treated by the licensed optometrist, ophthalmologist, or eye specialist of your choice. When you go to the doctor or purchase eyeglasses or contact lenses, you pay the full cost. You then apply for partial reimbursement from the program. Each calendar year, the program pays for you and each covered family participant:

- Up to $35 for an annual routine eye examination.
- Up to:
  - — $35 a pair for single vision lenses.
  - — $52.50 a pair for bifocal lenses.
  - — $70 a pair for trifocal lenses.
  - — $87.40 a pair for lenticular lenses.
  - — $5 for tinting.
- Up to $35 a pair for frames.
- Up to $200 a pair for medically necessary contact lenses. The claims administrator must approve the medically necessary lenses before you can receive reimbursement for them. Contacts are considered medically necessary:
  - — Following cataract surgery;
  - — To correct extreme vision problems that cannot be corrected by eyeglasses;
  - — Certain conditions of anisometropia; and
  - — Keratoconus.

If your vision can be corrected with eyeglasses but you decide you want to purchase contact lenses, the program will pay $150 toward the cost for your eye exam and elective contact lenses. This benefit is the same regardless of whether you go to a participating provider or a nonparticipating provider.

Optional Services
The vision program is designed to provide you with necessary eye care and corrective eyeglasses. If you want to purchase certain optional services, you can buy these extras for an additional cost. Your network provider can tell you whether something is covered by the program or is considered an option.

Examples of options for which you pay extra money include:

- Blended lenses;
- Oversized lenses;
- Progressive multifocal lenses, *e.g.*, progressive bifocals;
- Coated or laminated lenses;
- Frames costing more than the program allowance;
- Certain cost for low vision care:
- Cosmetic lenses (lenses for eyeglasses that serve no corrective vision purpose);
- Ultraviolet-protected lenses; and
- Optional cosmetic processes.

Expenses Not Covered
The vision program does not pay any benefits for:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (noncorrecting);
- Two pairs of glasses instead of bifocals;
- Medical or surgical treatment for the eyes (this may be covered by the medical coverage, if you are enrolled in that program);
- Any eye examination or corrective eyewear required by an employer as a condition of employment;
- Lost, stolen, or broken eyeglasses or contact lenses; and
- More than one pair of eyeglasses or contact lenses during the calendar year.

You must notify the network provider's office of your network plan participation. Otherwise, you may be billed as a private patient. In this case, you may apply to the provider for reimbursement as a non-network expense and you will pay any charges above what the program pays.

Flexible Spending Accounts— Section E

Flexible Spending Accounts—Section E

Effective January 1, 2006, active employees covered by this Plan will be eligible to participate in two flexible spending accounts.

- Healthcare Flexible Spending Account ("Healthcare FSA"), with employee contributions up to $4,800 per year. Contributions are deducted from your pay on a pretax basis and may be used to pay for qualified medical, dental and/or vision expenses.

- Dependent Care Flexible Spending Account ("Dependent Care FSA"), allows you to contribute up to $4,980 per year (subject to applicable IRS limits).

Healthcare Flexible Spending Account ("FSA")

As an eligible active employee, you may use the Healthcare FSA to pay expenses for you and your eligible dependents that are not reimbursed by any other health care plan or coverage. The plan follows IRS Publication 502 (Medical and Dental Expenses), and generally includes the following eligible expenses:

- Annual deductibles or network service copayments, prescription drug copayments, and the participant's share of covered expenses.
- Amounts you pay in excess of a health care plan's limits, such as reasonable and customary fee reductions, additional mental health treatments, etc.
- Items or services not covered by a health care plan that are considered tax-deductible medical expenses by the IRS
- Health care items or services for which you do not have coverage.
- Fees for services performed by licensed physicians, dentists, chiropractors, podiatrists, optometrists, opticians, psychologists, osteopaths, therapists, nurses, and technicians.
- The cost of prescription drugs, insulin, and certain eligible over-the-counter items such as allergy medicines, pain relievers, nicotine gum or patches, etc. (as permitted by the IRS and detailed in the SPD).
- Expenses resulting from treatment in hospitals, clinics and other licensed medical facilities.
- Prosthetic devices, including artificial limbs, artificial teeth, crutches, dentures, eyeglasses, and hearing aids.
- Expenses resulting from illness and procedures including, but not limited to the following examples:
  - Acupuncture
  - Braces
  - Braille – books and magazines

- Contact lenses
- Convalescent care facility
- Diagnostic fees
- Eye care expenses
- Guide dog and upkeep
- In-vitro fertilization
- Laboratory fees
- Lamaze classes
- Orthodontia
- Oxygen
- Psychiatric care
- Therapeutic care for drug and alcohol addiction
- Wheelchairs
- X-rays

Ineligible Healthcare FSA Expenses

The following is a partial list of healthcare expenses (such as professional services and medical treatments, equipment and supplies, and miscellaneous expenses) that are not eligible for reimbursement through the Healthcare FSA.

- Professional Services and Medical Treatments:
  - Athletic or health club memberships
  - Babysitting fees to enable you to receive medical treatment
  - Cosmetic surgery that is not medically necessary
  - Deductions from employee wages to pay for any state or employer sponsored healthcare coverage
  - Domestic help, except for nursing duties
  - Marriage counseling fees
  - Medical treatments, services or medicines that are illegal in the location where you receive them

- Equipment and Supplies
  - Air conditioner, even if prescribed by a physician.
  - Bottled water bought to avoid drinking fluoridated city water
  - Cosmetics

- Piercings
- Special food or beverage substitutes
- Miscellaneous articles, such as toothpaste and other toiletries.

- Over-the-counter items
  - Aromatherapy
  - Baby oil, wipes, bottles, etc.
  - Cosmetics
  - Dental floss
  - Deodorants
  - Facial Care
  - Feminine Care
  - Hair Regrowth
  - Special diet foods
  - Oral care
  - Shampoo and conditioners
  - Skin care
  - Sun tanning products

- Miscellaneous
  - Expenses incurred before the employee began participating in the Healthcare FSA
  - Expenses incurred after the employee ceased participation
  - Antiseptic diaper services
  - Funeral, cremation, burial, cemetery plot, monument, or mausoleum expenses
  - Health programs offered by resort hotels, health clubs, and gyms
  - Maternity clothes
  - Expenses of a former spouse
  - Premiums for life insurance policies, disability income policies.
  - Premiums for any health care coverage
  - Premiums for Long Term Care Insurance
  - Transportation costs of a disabled person to and from work
  - Tuition and travel expenses to send a problem child to a special school for a beneficial change in environment
  - Veterinary fees.

If the FSA reimburses you for an ineligible expense, it is your responsibility to repay the money.

Dependent Care FSA

Eligible active employees may use the Dependent Care FSA to pay certain employment-related dependent care expenses. These are expenses you pay to a care provider or center for the care of your dependent while you work. The account also reimburses expenses if you work and your spouse is a full-time student.

The IRS limits eligible dependents to your dependents under age 13 who can be claimed as an exemption on your federal income tax form; and your dependents of any age (including parents) who are physically or mentally incapable of self-care and depend on you for at least 50% of their support; an incapacitated dependent who is age 13 or over must regularly live in your household at least eight hours a day.

The IRS has certain restrictions on the use of the Dependent Care FSA. The only expenses you may claim are those that would otherwise qualify for the dependent care tax credit on your federal income tax return. Further, reimbursements received through the Dependent Care FSA may not also be claimed as a tax credit on your federal income tax return.

The Plan follows IRS Publication 503 (Child and Dependent Care Credit) to determine eligible expenses. Below is a partial list of eligible Dependent Care expenses:

- Licensed care centers, nursery school, and pre-school, if the care center or school complies with the state and federal regulations
- Babysitter costs, or wages or salary for a care provider inside or outside your home; if the care provider is a relative, he or she must be age 19 or older, and cannot be your dependent.
- Nonresidential dependent nursing or custodial care in your home for an elderly or disabled dependent who is unable to care for himself or herself
- Social Security and other taxes you pay on behalf of a care provider

Note: You must include the Social Security number or tax ID number of the person or center providing the care in order to qualify for reimbursement.

Dependent Care FSA Ineligible Expenses

The following is a partial list of dependent care expenses that are not eligible for reimbursement through the Dependent Care FSA.

- Expenses you incurred before you began participating in the Dependent Care FSA
- Payments provided by someone you claim as a dependent on your federal income tax return.
- Payments to your child (or stepchild) who is under age 19 at the end of the taxable year
- Schooling costs for your children in kindergarten or older (if the cost of care can be separated from the cost of schooling, only the cost of care is an eligible expense)
- Amounts you claim as a tax credit on your federal income tax return for the calendar year

- Overnight camp expenses
- Transportation expenses for travel to and from the dependent day care provider
- Finder's fees for placement of an au pair or nanny
- Expenses incurred for a dependent during any period in which you cannot claim that individual as a dependent for income tax purposes.
- Expenses incurred after your participation ceases.

If the FSA reimburses you for an ineligible expense, it is your responsibility to repay the money.

Claims and Account Forfeitures

Claims for a calendar year must be **received** by the claims administrator by March 31 of the following calendar year to be eligible for reimbursement. Claims are processed weekly, and a claim must total at least $10 to be processed (except for the final reimbursement from the account for the year).

The Healthcare FSA and Dependent Care FSA accounts are separate. Money cannot be transferred between the two FSA accounts for any reason.

The IRS requires that participants forfeit any balance in their FSA account(s) not used for eligible expenses incurred during the calendar year. **Participants cannot carry over a balance in an FSA from one calendar year to the next.** If you do not have enough eligible expenses to claim all deposits to the FSA, the law requires the Plan to forfeit your money remaining in the FSA account.

Coordination of Benefits (COB)—Section F

Coordination of Benefits (COB)—Section F

Coordination of Benefits with Other Group Plans
The Medical, Dental and Vision Plans coordinate benefits with other plans in which you or a covered dependent participate. Coordination with other health plans will provide a total benefit of not more than the benefits the CNH Plan would pay if it were primary. This approach does not provide for 100% reimbursement of health care expenses.

Definitions
Plan means a plan which provides benefits or services for or by reason of medical care and which is:

- A group insurance plan; or
- A group blanket plan; or
- A group practice plan; or
- A group service plan; or
- A group prepayment plan; or
- Any other plan which covers people as a group; or
- A government program or coverage required or provided by any law, including any motor vehicle no-fault coverage which is required by law.

Each policy, contract, or other arrangement for benefits or services will be treated as a separate Plan. Each part of such a Plan which reserves the right to take the benefits or services of other Plans into account to determine its benefits will be treated separately from those parts which do not.

This Plan means only those parts of This Plan which provide benefits or services for medical care. The provisions of This Plan which limit benefits based on benefits or services provided under:

- Government plans; or
- Plans which the employer (or an affiliate) contributes to or sponsors; or
- will not be affected by this Coordination of Benefits provision.

For the purpose of applying this provision, if both spouses are covered as employees under This Plan, each spouse will be considered as covered under separate Plans.

Allowable Expense means any reasonable and customary charge which meets all of the following tests:

- It is a charge for an item of necessary medical expense; and
- It is an expense which an Employee or Dependent must pay; and
- It is an expense at least a part of which is covered under at least one of the Plans which covers the person for whom claim is made.

When a Plan provides fixed benefits for specified events or conditions rather than benefits based on expenses, any benefits under that Plan will be deemed to be Allowable Expenses.

When a Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

However, Allowable Expense does not include expense for services received because of:

- An occupational sickness; or
- An occupational injury.

Claim Determination Period means a period which starts on any January 1 and ends on the next December 31. However, a Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

Effect on Benefits
If you are covered by more than one group medical plan (and/or Medicare), the benefits you receive from the CNH Plan are subject to Coordination of Benefits (COB) rules.

COB rules prevent duplication or double payment of the provider's charges for services. One plan is considered primary and pays first. The other is considered secondary and pays second.

Under COB rules, your total receipt from your group plans (including Medicare) may be up to, but not more than, the benefits the CNH Plan would pay if it were primary.

This approach to COB does not provide for 100% reimbursement of healthcare expenses. Instead, it allows two programs together to pay what the CNH Plan would otherwise pay if it were the only Plan providing benefits. **Note:** These rules do not apply to any nongroup insurance you purchased yourself.

The sum of all benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the benefits payable under This Plan.

Determining Which Plan Pays First
When more than one Plan covers the person for whom Allowable Expenses were incurred, the order of benefit determination is:

1. **Nondependent/Dependent**
The Plan that covers the person other than as a dependent determines its benefits before the Plan that covers that the same person as a dependent.

2. **Dependent Child/Parents Not Separated or Divorced**
Except as stated in rule (3) below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents," the Plan of the parent whose date of birth (excluding year of birth) falls earlier in a year determines its benefits before the plan of the parent whose date of birth (excluding year of birth) falls later in that year. If both parents have the same date of birth (excluding year of birth), the Plan that covered the parent for the longer time determines its benefits before the Plan that covered the other parent for the shorter time.

However, if either Plan has not adopted this rule (2), both Plans will determine their benefits by determining the father's benefits before the Plan of the mother.

3. **Dependent Child/Separated or Divorced Parents**
If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for that child will be determined in this order:

(a) First, the Plan of the parent with custody of the child;

(b) Then, the Plan of the spouse of the parent with custody of the child; and

(c) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity that is obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the Plan that covers the child of that parent determines its benefits first. Then follow the above rules (3) (a), (b), or (c) to determine which Plan pays next. This paragraph does not apply with respect to any Claim Determination Period during which any benefits are actually paid or provided before that entity has actual knowledge of the terms of the court decree.

4. **Active/Laid-Off or Retired Employees**
The Plan that covers the person as an active employee (or as that employee's dependent) determines its benefits before the Plan that covers the same person as a laid-off or retired employee (or as that employee's dependent). If the Plan that covers such person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (4) will not apply.

5. **Longer/Shorter Time Covered**
If none of the above rules (1), (2), (3), or (4) determines the order of benefits, the Plan that has covered the person for the longer time determines its benefits before the Plan that covered the person for the shorter time. Any reduction in the benefits under This Plan will be

applied proportionately to each benefit that would have been paid in the absence of this COB provision.

Coordination With Medicare Benefits
Your medical benefits may coordinate with Medicare depending on your age and employment status. You and/or your dependents become eligible for Medicare upon reaching age 65, by becoming disabled, or if diagnosed with chronic renal disease.

Federal law determines the coordination of benefit rules regarding Medicare. However, in general, if you are actively working and either you or a covered dependent is Medicare eligible, your CNH coverage will be primary and Medicare will be secondary for you and your dependents. If you are disabled or retired, Medicare eligible, and your spouse does not have coverage for you based on their active employment, Medicare would be primary and your CNH coverage would be secondary. If you are disabled or retired and Medicare eligible, but your spouse is not eligible for Medicare, the CNH Plan will continue to pay primary for your spouse, but will be secondary for you.

As long as you are eligible for Medicare, the Medical Plan coordinates with both Medicare Parts A and B coverage, regardless of whether you elect Medicare coverage. This means the amount Medicare would pay is deducted from the amount This Plan would otherwise pay if it were the primary payer.

Coordination with Medicare is on a carve-out basis. The CNH Plan will calculate what it would pay if it were primary, then subtract the amount payable under Medicare to determine the Benefit payable from the CNH Plan. The total benefits payable by the CNH Plan will not exceed the amount the CNH Plan would have paid if it were primary.

Exchange of Information and Payments
This Plan may, without the consent of or notice to any person, give or receive any information about coverage, expenses, and benefits that is needed to apply this provision subject to applicable federal regulations.

To obtain all benefits available, a claim should be filed under each Plan that covers the person for whom Allowable Expenses were incurred. Any person who claims benefits under This Plan must give to This Plan the information needed to apply this provision.

This Plan has the right to recover any overpayment it makes from any party who benefited from the overpayment.

If payments that should have been made under This Plan were made under any other Plans, This Plan may pay the party that made the other payments any amounts which it deems proper under this provision. Amounts so paid will be deemed benefits under This Plan. This Plan will be fully discharged from liability to the extent of such payments.

Disability Plans
—Accident and Sickness Plan
—Layoff Disability Benefits
—Long-Term Disability Plan—
Section G

Disability Plans—Section G

- **Accident and Sickness Plan**
- **Layoff Disability Benefits**
- **Long-Term Disability Plan**

WEEKLY ACCIDENT AND SICKNESS BENEFITS

If, while covered under the Plan, you become totally disabled (as described below) because of a nonoccupational illness or injury, the amount of Weekly Accident and Sickness (A&S) Benefits provided by the Schedule below shall be paid to you each week during the continuation of such disability for up to 52 weeks.

Payment of Benefits

The Plan will pay a weekly disability benefit if, as a result of a nonoccupational sickness or injury occurring while you are covered for these benefits, you become disabled so as to be prevented from doing your job, or any other job for which you are otherwise fit by reason of education, training or experience, and you are under treatment by a licensed physician for that disability.

Amount of Weekly Benefit

The amount of the A&S weekly benefit is based upon your average hourly earnings with the employer as defined by the labor agreement, as follows:

Disabilities Beginning After April 1, 2005

Employee's Average Hourly Rate Earnings, as determined by Labor Agreement	A&S Benefit
Less than $10.45	**$250**
$10.45 but less than $10.80	**$255**
$10.80 but less than $11.15	**$260**
$11.15 but less than $11.50	**$265**
$11.50 but less than $11.85	**$270**
$11.85 but less than $12.20	**$275**
$12.20 but less than $12.55	**$280**
$12.55 but less than $12.90	**$285**
$12.90 but less than $13.25	**$290**
$13.25 but less than $13.60	**$295**
$13.60 but less than $13.95	**$300**
$13.95 but less than $14.30	**$305**
$14.30 but less than $14.65	**$310**
$14.65 but less than $15.00	**$315**
$15.00 but less than $15.35	**$320**

Employee's Average Hourly Rate Earnings, as determined by Labor Agreement	A&S Benefit
$15.35 but less than $15.70	**$325**
$15.70 but less than $16.05	**$330**
$16.05 but less than $16.40	**$335**
$16.40 but less than $16.75	**$340**
$16.75 but less than $17.10	**$345**
$17.10 but less than $17.45	**$350**
$17.45 but less than $17.80	**$355**
$17.80 but less than $18.15	**$360**
$18.15 but less than $18.50	**$365**
$18.50 but less than $18.85	**$370**
$18.85 but less than $19.20	**$375**
$19.20 but less than $19.55	**$380**
$19.55 but less than $19.90	**$385**
$19.90 but less than $20.25	**$390**
$20.25 but less than $20.60	**$395**
$20.60 but less than $20.95	**$400**
$20.95 but less than $21.30	**$405**
$21.30 but less than $21.65	**$410**
$21.65 but less than $22.00	**$415**
$22.00 but less than $22.35	**$420**
$22.35 but less than $22.70	**$425**
$22.70 but less than $23.05	**$430**
$23.05 or more	**$435**

One-fifth of the Weekly A&S benefit amount will be paid to you for each work day you are absent due to total disability.

Effective for disabilities commencing after April 1, 2005, the calculation of your "Base Hourly Rate" to determine the benefit amount for A&S Benefits and Long Term Disability benefits will be continued on the present calendar quarter schedule. The calculation in all instances will include: shift premium and the other items which were included under the 1998 contract, except overtime premium, provided that the added COLA to be included for the life of the new contract will be $4.00 accumulated under prior agreements for Employees hired before May 2, 2004. No other COLA is included. Further, Average Hourly Rate will be based on average earnings in the third calendar quarter of 2004 until the end of the second quarter of 2005.

If you are receiving treatment for substance abuse as provided in the Plan, the waiting period for A&S Benefits will be eliminated, provided CNH will have the right to designate the approved facility for treatment of repeat confinements.

Disabilities resulting from pregnancies will be considered for A&S weekly benefits and Long Term Disability benefits as other disabling illnesses or injuries.

Duration of Benefits

Benefits will commence on the first day of total disability due to accidental injury or the eighth day of total disability due to illness. However, benefits will commence with the first day of hospitalization occurring during such period of disability or with the day on which a covered surgical procedure is performed without hospitalization for which the physician's fee is $25 or more.

Weekly benefits will continue during total disability for up to a maximum of 52 weeks for employees who have at least 52 weeks seniority for any one continuous period of disability whether for one or more causes. Successive periods of disability that are due to the same or related cause or causes will be considered as one continuous period of disability unless separated by at least 90 days.

If you have less than 52 weeks seniority when first disabled, you will receive benefits for a period equal to your seniority when first disabled rather than a full 52 weeks. However, benefits may continue beyond a period equal to seniority up to the full 52 weeks while you are hospitalized or drawing Worker's Compensation Benefits.

Limitations

The amount of weekly benefits for a continuous period of disability is the amount in effect at the time that period of continuous disability starts. The amount of weekly benefits will be reduced by the amount you receive from any fund, other insurance or other source of disability or income benefits provided by state or governmental law.

Your weekly benefits will be reduced by the amount payable to which you are entitled during a period of disability under Social Security, or under any occupational or disease law, even if you do not make a proper request to receive such benefits. You must notify the Plan when you receive such benefits or if your benefits are increased.

After weekly benefits are payable, any increase in Social Security will not be used to reduce your benefits.

Weekly benefits are also payable for an approved leave of absence due to a clinically anticipated disability based on the natural course of your diagnosed condition, provided CNH receives satisfactory medical certification from your attending physician that you are totally disabled.

If you are on layoff and no longer receiving any layoff benefits under this section G, you will not re-establish eligibility for weekly benefits until you have returned to active service and performed work.

In the event of a contested claim for Worker's Compensation benefits, you will receive an amount of money equal to your current A&S Benefit rate. You will be required to sign a reimbursement form which will provide that any Worker's Compensation judgment in your favor which duplicates a payment previously made by CNH or the Plan, will be returned to CNH or the Plan by you, or deducted from any final settlement CNH or the Plan may be required to make.

Occupational Disabilities
A&S weekly benefits are not payable for disabilities resulting from occupational illness or injury. CNH shall, however, supplement Worker's Compensation weekly benefits in order to provide a total benefit level that is equivalent to the A&S weekly indemnity rate including such payment during the Worker's Compensation initial waiting period.

In the event you return from an occupational disability absence and are assigned to a lower rated job because of an occupational disability with a resulting loss of pay, your benefit payments, should you again become disabled, will be based on the highest hourly wage rate that you received within the last six months prior to the time the occupational injury or disability occurred. Benefits shall be determined in the aforementioned manner until six months after you recover from your disability and are physically capable of performing a job as highly rated as the job you had prior to the occupational disability.

Exclusions
Weekly benefits are not payable for any period during which you are receiving benefits from a pension plan of CNH, to which CNH has contributed.

Weekly benefits are not payable for any day you receive holiday pay from CNH.

Layoff Disability Benefits (Sub-Plan)

Eligibility
You will be eligible for Layoff Disability Benefits if you meet all of the following conditions:

- You are on a qualified layoff under the Supplemental Unemployment Benefit Plan;
- You are eligible for a benefit under the Sub-Plan immediately prior to the time you became disabled, or, if not so eligible, you were employed by another employer at such time;[1]
- You are totally disabled by disease or accidental injury so as to be unable to perform any job for CNH;
- You are under the care of a physician; and
- You are not eligible for A&S benefits or Long Term Disability benefits.

Amount
The weekly Layoff Disability Benefit will be equal to the A&S weekly benefit that applies to you. Layoff Disability benefits will be reduced by the amount of any disability benefit you received for the same week or portion thereof under a plan of another employer.

Period of Payment
Payment of Layoff Disability Benefits will commence on the first day of disability, or the day immediately following the last day for which a benefit is payable under the SUB-Plan, whichever is later. Payment will cease upon the earlier of:

[1] *Note:* This requirement does not apply to an employee who is ineligible for a regular benefit under the Sub-Plan because of failure to meet the requirements of the UC earnings test.

- Exhaustion of all full SUB credit units;
- Recovery from total disability;
- Recall from layoff; or
- If you are otherwise eligible for Layoff Disability Benefits, you will continue to receive the benefit until exhaustion of all full SUB credit units under the cancellation provisions of the Plan – regardless of the status of the SUB fund. After SUB credit units have been exhausted, employees otherwise eligible will continue to receive Layoff Disability Benefits for a period of up to 52 weeks from the date of layoff in the amount of the applicable state UC benefit or $150, whichever is greater per week.

Special Provisions
If you are recalled from layoff while receiving Layoff Disability Benefits and immediately qualify for A&S benefits, the maximum number of weeks for which such A&S benefits are payable shall be reduced by the number of weeks for which Layoff Disability benefits were paid.

If you cease to be totally disabled and remain on a qualifying layoff under the SUB Plan, Layoff Disability benefits shall be payable for the remaining days in the same week (as defined in the SUB Plan) for which you do not receive a regular benefit under the SUB Plan.

You may waive irrevocably any right to receive Layoff Disability benefits—with respect to any period of disability—by completing a waiver form furnished by CNH. No Layoff Disability benefits shall be payable for the period covered by such waiver.

Long-Term Disability Benefits

If, while covered, you become totally disabled, as defined below, the Plan will pay you a monthly benefit during the continuance of your total disability for up to the maximum benefit period specified below.

Definition of Total Disability
"Totally disabled" or "total disability" means that, because of a sickness or injury, you are unable to engage in any gainful occupation or employment for which you are reasonably qualified by education, training or experience.

You will be required to furnish proof to the Plan of disability. The Plan may, at its own expense, request a physical examination by a physician of its choosing for any employee, making a claim under this coverage. In certain cases, it may be necessary for the Plan to request additional medical evaluations in order to determine eligibility for benefits.

Payment of Benefits

The Plan will pay you the monthly benefit described below if, while eligible for this benefit, you become totally disabled. Payment of this benefit will be subject to the limitations, exclusions and reductions described in this section G.

Amount of Monthly Benefit

The amount of the Long Term Disability benefit is based upon your average hourly earnings and years of service with CNH as of the day you become totally disabled, as follows:

Disabilities Beginning After January 1, 2005

	Monthly Benefit	
Employee's Average Hourly Rate Earnings, as determined by the Employer	**Less Than 10 Years**	**10 Years or More**
Less than $10.45	**$890**	-
$10.45 but less than $10.80	**$910**	-
$10.80 but less than $11.15	**$930**	-
$11.15 but less than $11.50	**$950**	-
$11.50 but less than $11.85	**$970**	-
$11.85 but less than $12.20	**$990**	-
$12.20 but less than $12.55	**$1,010**	-
$12.55 but less than $12.90	**$1,035**	-
$12.90 but less than $13.25	**$1,055**	-
$I3.25 but less than $13.60	**$1,075**	-
$13.60 but less than $13.95	**$1,100**	**$1,225**
$13.95 but less than $14.30	**$1,120**	**$1,245**
$14.30 but less than $14.65	**$1,140**	**$1,265**
$14.65 but less than $15.00	**$1,155**	**$1,285**
$15.00 but less than $15.35	**$1,175**	**$1,305**
$15.35 but less than $15.70	**$1,200**	**$1,330**
$15.70 but less than $16.05	**$1,220**	**$1,350**
$16.05 but less than $16.40	**$1,240**	**$1,370**
$16.40 but less than $16.75	**$1,260**	**$1,390**
$16.75 but less than $17.10	**$1,280**	**$1,410**
$17.10 but less than $17.45	**$1,300**	**$1,435**
$17.45 but less than $17.80	**$1,325**	**$1,455**
$17.80 but less than $18.15	**$1,345**	**$1,475**
$18.15 but less than $18.50	**$1,365**	**$1,495**
$18.50 but less than $18.85	**$1,385**	**$1,515**
$18.85 but less than $19.20	**$1,405**	**$1,540**
$19.20 but less than $19.55	**$1,430**	**$1,560**
$19.55 but less than $19.90	**$1,450**	**$1,580**
$19.90 but less than $20.25	**$1,470**	**$1,600**

Employee's Average Hourly Rate Earnings, as determined by the Employer	Monthly Benefit	
	Less Than 10 Years	10 Years or More
$20.25 but less than $20.60	**$1,490**	**$1,620**
$20.60 but less than $20.95	**$1,510**	**$1,645**
$20.95 but less than $21.30	**$1,535**	**$1,665**
$21.30 but less than $21.65	**$1,555**	**$1,685**
$21.65 but less than $22.00	**$1,575**	**$1,705**
$22.00 but less than $22.35	**$1,595**	**$1,725**
$22.35 but less than $22.70	**$1,615**	**$1,745**
$22.70 but less than $23.05	**$1,635**	**$1,765**
$23.05 or more	**$1,655**	**$1,785**

Effective for disabilities commencing after January 1, 2005, the calculation of your "Base Hourly Rate" to determine the benefit amount for A&S Benefits and Long Term Disability benefits will be continued on the present calendar quarter schedule. The calculation will include your base hourly rate (Schedule A, B, or C), incentive earnings (for Schedule B employees only), RCPL (if eligible), CCICS rates (if applicable), shift premium, and other items which were included under the prior contract, except overtime premium, provided that the added COLA to be included for the life of the new contract will be **$4.00** accumulated under the prior agreements for employees hired before May 2, 2004. No other COLA is included.

Duration of Benefits

Monthly benefits will commence on the day following the date that A&S weekly benefits cease. As long as you remain totally disabled and under the regular care of a physician, monthly benefits will continue until:

- If the total disability commenced prior to age 60, the earlier of:
  - — For a period equal to your seniority on the date you became disabled, less one year; or
  - — The day preceding your 65th birthday.
- If the total disability commenced on or after age 60 but prior to age 63 up, the earlier of:
  - — The date you have received 60 monthly Long Term Disability payments; or
  - — The day preceding your 70th birthday.
- If the total disability commenced on or after age 63 but prior to age 65, the date you have received 24 monthly Long Term Disability payments under the Plan.
- If the total disability commenced on or after age 65, the date you have received 12 monthly Long Term Disability payments under the Plan.

The maximum duration of benefits specified above is the maximum for any one period of total disability whether from one or more causes. Successive periods of total disability due to the same or related cause or causes will be considered as one continuous period of disability unless separated by at least 90 days of return to active work with the employer.

Exclusions
In no case are monthly benefits payable for any period of total disability:

- During which you are not under the care of a licensed physician;
- Caused by or resulting from intentionally self-inflicted injury;
- Resulting from, caused or contributed to by the commission of a felony;
- Caused by or resulting from war or act of war, any act of international armed conflict, or conflict involving the armed forces of any international authority;
- During which you engaged in any gainful occupation, other than rehabilitative employment; or
- If you fail to give the required proof of continued disability, or refuse to be examined by a doctor, as required by the Plan.

"Rehabilitative Employment" means a type of employment that the Plan recognizes as employment designed to rehabilitate you while you are totally disabled and for which you receive wages or profit. You will not be ineligible for Long Term Disability benefits because of work that is determined to be primarily for training under a recognized program of vocational rehabilitation. During the first two years Long Term Disability benefits are payable, the earnings from such rehabilitative employment shall not be deducted from the Long Term Disability benefits. Thereafter, such earnings shall be deducted.

Reductions in the Amount of Your Monthly Benefit
The amount of your monthly benefit will be reduced by the sum, if any, of the amounts listed below. Each of these amounts will be considered received by you when you are entitled to receive it, even though you may actually amount receive the amount at a later date. The amounts that will be used to reduce your monthly benefit are:

- Primary Social Security benefit.
- Retirement benefits provided under the CNH U.S. Pension Plan.
- Workers' Compensation benefits.
- Disability benefits under any state or government plan.
- Disability benefits under any other company-sponsored plan.
- The amount of widow's benefit available under Social Security.

Long Term Disability benefit computations shall presume eligibility for Social Security Disability Insurance benefits, and if you have 10 years of service, total and permanent disability pension benefits. Deductions from Long Term Disability benefits will be made on this basis unless you provide satisfactory evidence that these benefits were applied for and denied; provided however, that a reduction shall be made in the amount equal to Social Security Disability Insurance benefits that would have been payable except for refusal to accept vocational rehabilitation services.

In determining the amount by which Long Term Disability benefits shall be reduced, the monthly equivalent of benefits paid on a weekly basis will be computed by **multiplying** the weekly benefit rate by **4.33**. In the case of lump-sum settlements under Workers' Compensation, the reduction will be equal to the amount of Workers' Compensation benefit to which you would have been entitled under applicable law had there been no lump-sum payment, but not to exceed in total the amount of the settlement.

The cumulative total number of months during any previous periods of eligibility for Long Term Disability benefits, regardless of whether for the same or related disabling condition, reduces the maximum number of monthly benefit payments for which you are otherwise eligible should Long Term Disability benefits again commence.

The reduction of benefits for which you are eligible under Workers' Compensation laws or other laws providing benefits for occupational injury or disease, including lump-sum settlements, shall exclude specified allowances for loss, or 100% loss of use of a bodily member.

Increases in Social Security, Workers' Compensation, pension, or disability benefits provided under any government plan occurring after the initial date Long Term Disability benefits are payable will not be offset against Long Term Disability benefits. Redeterminations of pension or Social Security benefits which result in greater benefits will be offset.

In the event you apply for benefits and they are denied under the above specified programs, the Long Term Disability benefits shall not be reduced. Your failure to apply shall, however, cause the Long Term Disability benefits to be reduced by an amount which would have been payable except for the failure to apply.

If you are on layoff and no longer receiving any layoff benefits under Section G, you will not re-establish eligibility for Long Term Disability benefits until you have returned to active service and performed work.

Life Insurance Plans
—Life
—Accidental Death and Dismemberment
—Survivor Income Benefits—
Section H

Life Insurance Plans—Section H

- **Life**
- **Accidental Death and Dismemberment**
- **Survivor Income Benefits**

The Life Insurance Benefits described in this section are designed to provide a benefit in the event of your death or total and permanent disability while you are covered under the Plan and eligible for these benefits.

Amount of Benefit
If you die while covered for this life insurance benefit, the Plan will pay to your beneficiary of record the amount of your Basic Noncontributory Life Insurance as indicated in the following table:

Effective January 1, 2005, the amount of Basic Noncontributory Life Insurance is:	
If You Were Hired Prior to May 14, 1998	**If You Were Hired On or After May 14, 1998**
$46,000	$22,000

Total and Permanent Disability Installment Benefits
If you become totally and permanently disabled after having attained at least two years seniority— but prior to attaining age 65—and you do not qualify for a Normal, Regular Early, or Disability Pension under the CNH U.S. Pension Plan, you may elect to receive your Basic Noncontributory Life Insurance benefit in monthly installments in lieu of a death benefit.

Each monthly installment will be payable at a rate equal to $20 for each $1,000 of your Basic Noncontributory Life Insurance under the Plan. The insurance company will retain $500 of your Basic Noncontributory Life Insurance under the Plan as a death benefit.

The first of such installments will be payable on the later of:

- The first day of the month coinciding with or next following the date you are no longer eligible to receive A&S Disability Benefits and Monthly Long-Term Disability Benefits; or
- The first day of the month following the date the required proof of disability has been submitted to the insurance company.

If you die during a period in which Total and Permanent Disability monthly installments are being paid to you under the Plan, then any remaining installments will be paid to your beneficiary of record in a lump sum of not less than $500. If you die after all such installments have been paid, your beneficiary of record will receive $500 under the Plan.

In the event you return to active employment with CNH after receiving payments of your Life Insurance in installments, the amount of insurance in effect after the return to work shall be the

amount to which you are entitled under the Plan then in effect. The amount of insurance in effect for further payment of monthly installments in the event of future disability shall be reduced by the total amount of the installment payments previously made.

Continued Protection in the Event of Total and Permanent Disability
If you do not elect the monthly installment payout option, Life Insurance coverage in the amount listed below will be continued:

If you die with 5 or more years of service*	**Effective on and after January 1, 2005, provided that you are at work on that date and hired *before* May 14, 1998**	**For employees hired on or after May 14, 1998**
Before reaching age 65	$46,000	$22,000
Age 65 but less than age 66	$34,500	$16,500
Age 66 or older	$23,000	$11,000

* No benefits will be provided if you die with less than five years of service.

The continuation of coverage will continue if you:

- Are totally disabled while Life Insurance coverage is in effect.
- Are under age 65 when the total disability commences.
- Continue to be totally disabled until the date of death.

The Life Insurance benefit will be payable when:

- The total disability continued for at least nine months.
- You continue to provide proof that the total disability continues. You will not be required to provide proof of continued disability more than once a year.

Definition of Total and Permanent Disability
You will be deemed to be totally and permanently disabled if you are unable, due to physical or mental incapacity, to perform any job for which you are qualified by reason of education, training, or experience.

Limitations
You may be required to undergo an independent medical examination by a doctor of the insurance company's choice, at no cost to you. You will not be required to undergo the examination more than once a year.

If you do not provide proof of total disability, when required, the Life Insurance benefits will cease.

Optional Contributory Life Insurance

In addition to the basic plan of Noncontributory Life Insurance, you will be offered the option of choosing an additional amount of Contributory Life Insurance under one of the plans shown below.

Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
$5,000	$10,000	$15,000	$20,000	$30,000	$40,000	$50,000

You will be required to contribute to the cost of this additional coverage, as determined by the life insurance company. Premiums must be paid monthly through payroll deduction. Also, the Accidental Death and Dismemberment Coverage and total and permanent disability provisions that apply to Basic Noncontributory Life Insurance will not apply to this additional coverage.

If you are on layoff or receiving weekly Accident and Sickness benefits, you may elect to continue coverage for a period of time equal to the basic life extension, up to one year, by paying the appropriate monthly contribution.

Once you select an amount of Optional Contributory Life Insurance, you cannot change to a higher or lower amount unless you make written request to the insurance company. In addition, you will have to submit evidence of your good health before you can change to a higher amount.

Beneficiary

- Your beneficiary is the person or persons you choose in writing on a form approved by the insurance company and filed with your local benefits office to receive any benefit payable because of your death.

You may change your beneficiary at any time by filing a new form with your local benefits office. You do not need the consent of the beneficiary to make a change. When you submit a form changing your beneficiary, the change will take effect as of the date you signed it. The beneficiary change will take effect even if you are not alive when the form is received by your local benefits office.

A change of beneficiary will not apply to any payment made by the Plan prior to the date the form was received by CNH.

- If you designate more than one beneficiary, they will share in the benefits equally, unless you have chosen otherwise.

- A person's right as a beneficiary ends if that person dies before your death occurs. (The share for that person will be divided among the surviving persons you have named as beneficiary, unless you have chosen otherwise.)

- If there is no designated beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to your estate. However, the Plan may instead pay all or part of that amount to one or more of the following persons who are related to you and who survive you:

— Spouse;

— Parent; and/or

— Child.

Any payment will discharge the Plan's liability for the amount so paid.

Accidental Death and Dismemberment (AD&D) Insurance

Covered Expenses
If you are injured in an accident, AD&D benefits will be paid:

- If the accident occurs while you are covered for AD&D benefits; and
- If that accident is the sole cause of the injury; and
- If that injury is the sole cause of a Covered Loss; and
- If that Covered Loss occurs not more than two years after the date of such accident.

The maximum benefit for all losses caused by all injuries that you sustain in one accident is $23,000 or $11,000 depending on your hire date.

In the event you die as the result of a work incurred accident for which Workers' Compensation benefits are payable by CNH, the amount payable is $46,000. If you were hired on or after May 14, 1998, the amount payable is $22,000.

Table of Covered Losses and Benefits Amounts

Covered Losses (Subject to Exclusions)	**Benefits Amount**	
	If You Were Hired Prior to May 14, 1998	**If You Were Hired On or After May 14, 1998**
Loss of life	$23,000	$11,000
Loss of sight in both eyes	$23,000	$11,000
Loss of both hands	$23,000	$11,000
Loss of both feet	$23,000	$11,000
Loss of one hand or one foot, together with loss of sight of one eye	$23,000	$11,000
Loss of one hand	$11,500	$5,500
Loss of one foot	$11,500	$5,500
Loss of sight in one eye	$11,500	$5,500

Loss of sight of an eye means that the eye is entirely blind and that no sight can be restored in that eye.

Loss of a hand means that all of the hand is severed at or above the wrist.

Loss of a foot means that all of the foot is severed at or above the ankle.

Exclusions
Each of the above losses is not a Covered Loss if it in any way results from, or is caused or contributed to by:

- Physical or mental illness, diagnosis of or treatment for the illness;
- An infection, unless it is caused by an external wound that can be seen and which was sustained in an accident;
- Suicide or attempted suicide;
- Injuring yourself on purpose;
- Hernia, no matter how or when sustained; and
- A war, or a warlike action in time of peace.

Survivor Income Benefit Insurance
(Note: Employees hired on or after May 14, 1998, are not eligible for Survivor Income Benefits.)

In the event of your death due to any cause, Survivor Income Benefits Insurance will provide for up to 24 months a monthly Transition Survivor benefit for either your surviving spouse, children, or parents who qualify as a Class 1, Class 2, or Class 3 Survivor respectively, as defined below.

In addition, after receiving 24 months of Transition Survivor benefits, your surviving spouse could qualify for monthly Bridge Survivor benefits depending on his or her age and your years of service.

Transition Survivor Benefit
A monthly Transition Survivor benefit will be payable for up to 24 months to the survivor or survivors in the first of the following classes in which there is an eligible survivor at your death. The classes and the order in which eligible survivors qualify for benefits are as follows:

- **Class 1: Your Spouse**—If he or she was married to you for at least one year immediately prior to your death.
- **Class 2: Your Child**—If unmarried and under 21 years of age at the time each monthly benefit is payable (must be a natural or legally adopted child).
- **Class 3: Your Parent**—If, during the calendar year preceding your death, you provide at least 50% of your parent's support.

If you die as the result of a work incurred accident or illness for which Workers' Compensation benefits are payable by CNH, your surviving spouse will be entitled to continue Medical, Prescription Drug, Dental and Vision coverage at the applicable participant contribution level. Such coverage shall cease on your surviving spouse's remarriage, attainment of age when your surviving spouse is eligible for Medicare, or upon death.

The continued coverage for your surviving spouse during such period will include children who would have been covered as your dependents had you not been deceased. If your surviving spouse's coverage ceases because of death or remarriage, coverage for your children will continue at the applicable participant contribution level for as long as the children would have continued coverage if your surviving spouse had not died or remarried.

The monthly Transition Survivor Benefit will be payable on the first day of the calendar month after your death. This payment will continue until the earlier of:

- The date 24 monthly Transition Survivor Benefits have been paid; or
- The date that no eligible survivors are left in any class of survivors.

Amount of Transition Survivor Benefit
Effective January 1, 2005, the amount of the monthly Transition Survivor Benefit will be as follows for persons who become eligible on or after that date:

- $600 for each month in which there is no eligible survivor in the class who is eligible for an unreduced benefit under Social Security; and
- $300 for any month in which any eligible survivor in the class is eligible for an unreduced benefit under Social Security.

Bridge Survivor Benefits
Your surviving spouse is eligible for a monthly Bridge Survivor Benefit if, at your death, he or she is at least 45 or if your spouse's age at the time of your death plus your years of service total 55 or more.

If your surviving spouse is eligible for Bridge Survivor Benefits and your death occurred on or after January 1, 2005, your surviving spouse and your children who would have been covered as your dependents will receive 12 months of Medical, Prescription Drug, Dental and Vision Coverage at the applicable participant contribution level. Such coverage will count toward your surviving spouse's and dependent children's maximum COBRA continuation period.

The first monthly Bridge Survivor Benefit will be payable on the first day of the calendar month after 24 monthly Transition Survivor Benefit payments have been paid. The monthly Bridge Survivor Benefits will continue until the earliest of:

- The date your surviving spouse remarries;
- The date your surviving spouse dies; or

- The date your surviving spouse reaches:

  — Age 62 and one month; or

  — Any lower age at which full benefits become payable under the federal Social Security Act.

Bridge Survivor Benefits will be $600 per month for persons who become eligible on or after January 1, 2005.

Any Survivor Income Benefits payable under the Plan are in addition to your Life Insurance.

No Survivor Income Benefits payable under the Plan shall be subject, in any manner, to assignment, pledge, attainment, or encumbrance of any kind, nor subject to the debts or liability of any eligible survivor except as required by applicable law.

Life Insurance—Conversion

If you should cease active work for any reason, including layoff or leave of absence, you should find out immediately from the benefits office what arrangements, if any, can be made to continue your life insurance benefits in force, so that you will be able to exercise any rights you may then have under the Plan, such as conversion.

To apply for conversion, contact your local benefits office. You may be able to arrange to convert your life insurance protection to an individual policy if you act quickly. Life insurance up to the amount of your Basic Noncontributory Life Insurance may be continued under an individual policy, without evidence of insurability, provided you apply to the insurance company within 31 days of the cancellation date. The amount of the individual policy may, at your option, be increased by an amount equal to the total amount of Survivor Income Benefit payments (both Transition Survivor Benefit and Bridge Survivor Benefit payments) that would have been made had you died on the date of termination of employment.

If you should die within 31 days of your last day of work, your Life Insurance will be paid to your beneficiary. Because the Life Insurance benefit will be payable for death occurring during the 31 days after you leave CNH, the individual policy will not become effective until the 31-day period has expired.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) Continuation and USERRA (Uniformed Services Employment and Reemployment Rights Act of 1994)— Section I

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) Continuation and USERRA (Uniformed Services Employment and Reemployment Rights Act of 1994)—Section I

COBRA CONTINUATION

You have the right to continue health coverage for you and your eligible dependents if you lose your group health coverage.

Electing COBRA Coverage

You may elect COBRA coverage if you are a "Qualified Beneficiary." You are a Qualified Beneficiary if:

- You are an employee of CNH or an employee's spouse or dependent child who is covered by the Plan on the day before the Qualifying Event; or
- You are a child born to, or adopted by, or placed for adoption with an employee during an 18 (or 29) month period of COBRA continuation. You must otherwise be eligible for coverage and the employee must enroll you on a timely basis in accordance with the terms of the Plan.

You may elect COBRA coverage if you are a Qualified Beneficiary and you experience a Qualifying Event. A Qualifying Event is one of the following events that would otherwise cause you to lose coverage under the Plan within the Maximum Continuation Period:

If you are an employee:

- Termination of your employment (for any reason other than gross misconduct), or a reduction in your work hours below the amount necessary to be eligible under the Plan.

If you are the employee's spouse:

- Termination of the employee's employment (for any reason other than gross misconduct), or a reduction in the employee's work hours;
- The employee's death;
- The employee's entitlement to Medicare; or
- Divorce or legal separation from the employee.

If you are the employee's dependent child:

- Termination of the employee's employment (for any reason other than gross misconduct), or a reduction in the employee's work hours;

- The employee's death;
- The employee's entitlement to Medicare;
- Divorce or legal separation from the employee; or
- You cease to be eligible as a dependent child under the terms of the Plan.

If you are a retiree:

If CNH filed a Chapter 11 bankruptcy proceeding that causes the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary. The retired employee's spouse, surviving spouse and dependent children will also become Qualified Beneficiaries if bankruptcy causes the loss of their coverage under the Plan.

Benefits That May Be Continued
You may continue the following group health coverage if you were enrolled in that coverage on the day before the Qualifying Event.

- Medical/Prescription Drug
- Dental
- Vision

You may elect to continue each benefit separately or a combination of some or all three benefits. COBRA coverage is the same as the coverage enforced for similarly situated non-COBRA Plan participants and beneficiaries, and is subject to the same changes and benefits that occur for those individuals. You are entitled to the same rights as a similarly situated non-COBRA Plan participant in the benefits you select, including special enrollments and open enrollments.

Length of COBRA Coverage
The Maximum Continuation Period is:

- 18 months following the employee's termination of employment or reduction in hours. If the employee is entitled to Medicare at the time of a termination or reduction in hours, then your maximum period of continuation as a spouse or dependent child is the later of 36 months following the employee's Medicare entitlement, or 18 months following the termination or reduction.
- 36 month following the employee's death, the employee's entitlement to Medicare, the employee's divorce or legal separation or the child's loss of status as an eligible dependent.
- If the Qualifying Event is CNH's bankruptcy filing, then the following Maximum Continuation Periods apply for Qualified Beneficiaries:
  - A retired employee is covered for life;

- A retired employee's spouse and dependent children are covered for the life of the retiree and, if they survive the retiree, for 36 months after the retiree's death;

- If the retired employee is deceased at the time of the bankruptcy but the retiree's surviving spouse is covered by the Plan, then the surviving spouse is covered for life.

In general, the Maximum Continuation Period begins as of the date of the loss of coverage due to the Qualifying Event.

You may extend an 18-month continuation period caused by the employee's termination of employment or reduction in hours as follows:

- **Disability.** You can extend the 18 months to a total of 29 months following the original termination or reduction in hours if you were Social Security disabled at the date of the Qualifying Event or within the first 60 days thereafter. This extension applies to the disabled individual and all other family members who are also Qualified Beneficiaries.

- **Second Qualifying Event.** You can extend the 18 (or 29) months to a total of 36 months following the employee's original termination of employment or reduction in hours, if you experience a second Qualifying Event during the original 18 (or 29) month continuation period. A second Qualifying Event is limited to the employee's death, the employee's Medicare entitlement, divorce or legal separation, or child loss of status as eligible dependent. These events are only Qualifying Events if they would have caused a spouse or dependent child to lose coverage if the first Qualifying Event had not occurred.

Once the COBRA administrator has received notice of your Qualifying Event, it will send you an election form to complete and return.

CNH will provide notice to the COBRA administrator of the following Qualifying Events:

- The employee's termination of employment or reduction in hours;

- The employee's entitlement to Medicare; or

- The employee's death.

You are responsible for providing notice to CNH of other Qualifying Events. You must provide written notice of the following events to CNH:

- **Divorce/Legal Separation.** Within 60 days of the later of (a) the date of divorce or legal separation from the employee; or (b) the date you would otherwise lose coverage due to this event.

- **Child Loses Eligibility.** Within 60 days of the later of (a) the date you lose eligibility as a dependent child (for example, due to age, loss of student status, or marriage); or (b) the date you would otherwise lose coverage due to this event.

- **Social Security Disability Extension**. Within 60 days after the latest of:
  - The date the Social Security Administration determines you are disabled; or
  - The date of the employee's termination of employment or reduction of hours; or
  - The date on which you lose (or would lose) coverage under the terms of the Plan as a result of the employee's termination of employment or reduction of hours.

  You must provide a copy of the Social Security Administration's determination of your disability. You must provide this notice before the expiration of the original 18- month continuation period.

  If the Social Security Administration determines that you are no longer disabled before your COBRA coverage expires, then you must notify CNH in writing of this determination within 30 days of receiving it.

- **Second Qualifying Event**. Within 60 days of the later of (a) the date of the occurrence of a second Qualifying Event (*i.e.*, divorce, legal separation, employee entitlement to Medicare, or child loss of eligible dependent status); or (b) the date you would otherwise lose coverage due to the event had you still been covered under the Plan prior to COBRA.

  Your notice must be in writing and provide the following information:
  - Your name.
  - The employee's name (if different).
  - Your address and telephone number.
  - The nature of the event (*e.g.*, divorce, legal separation, child loss of eligible dependent status, Social Security disability, or second Qualifying Event).
  - The date of the event.

  You can deliver your notice in person, by mail, by fax or by e-mail. CNH reserves the right to request documentation that supports the occurrence of your Qualifying Event.

If you fail to provide proper written on a timely basis, you will lose all rights to COBRA coverage or extended COBRA coverage.

Electing and Paying For COBRA Coverage.
You will have a period of 60 days to elect COBRA coverage. After CNH receives notice of your Qualifying Event, the COBRA administrator will send you an election form to complete and return. The election period begins on the later of:

- The date your coverage would otherwise terminate under the Plan.
- The date CNH notifies you of the right to elect COBRA coverage.

If you fail to return your completed election form before the end of the election period, you will lose all rights to COBRA coverage.

If you initially reject COBRA, you may change your mind as long as you do so before the 60-day election period expires. However, in that case, your COBRA coverage will not become effective until you file your COBRA election form, which means you may have a gap in coverage.

An employee or the employee's spouse can elect coverage on behalf of all Qualified Beneficiaries in the family. Parents or guardians may act on behalf of minor children. All Qualified Beneficiaries in a family have the right to elect coverage independently.

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. If you elect COBRA, you may not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the Qualifying Event. You will also have the same special enrollment right at the end of the COBRA coverage if you get COBRA coverage for the maximum time available to you.

You cannot be charged more than 102% of the group cost in effect. If your coverage continues beyond 18 months because of Social Security disability, the contribution in the 19th through 29th months may be increased to 150% of the group cost. CNH can increase costs annually. You will receive cost information with your COBRA election form and when costs are increased thereafter.

You can pay your premium in cash or by check or money order. You should follow the payment instructions on the election notice that you receive from the COBRA administrator. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the election form. However, you must make your initial payment for COBRA coverage not later than 45 days after the date of your election. If you do not make your initial payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your initial payment must cover the cost of COBRA coverage from the time your coverage under the Plan would otherwise have terminated up through the end of the month before the month in which you make your first monthly payment. You are responsible for making sure that the amount of your initial payment is correct. You may contact the COBRA administrator to confirm the correct amount of your initial payment.

CNH will not process claims for payment until you have elected COBRA and made your first COBRA payment.

After you make your initial payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's coverage. The COBRA administrator may not send you a monthly bill. It is your responsibility to pay your COBRA contributions on time. If you make a monthly payment on or before the due date, your COBRA coverage under the Plan will continue for the next month without any break.

Although monthly payments are due in advance of the month of coverage, you will be given a grace period of 30 days from the first period of the month of coverage to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

However, if you pay a monthly payment later than the due date, but before the end of the grace period, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you incur while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

Special Election Rules

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("TAA Eligible employees"). Under the new tax provisions, TAA Eligible employees can either take a tax credit or get advance payment of 65% of premiums, paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_actindex.asp.

Further, as a result of the Trade Act of 2002, TAA Eligible employees who lose their employment as a result of import competition or transfer of production to other countries and who did not elect COBRA coverage upon initial loss of coverage, are entitled to elect COBRA coverage during a special second election period. TAA Eligible employees include those receiving a trade adjustment allowance under the Trade Act of 1974 (or eligible for such an allowance once unemployment compensation is exhausted) or receiving alternative trade adjustment assistance under the Trade Act of 1974; who have lost health plan coverage due to termination of employment that resulted in eligibility for a trade readjustment allowance or alternative trade adjustment assistance, and who provide a certified copy of the certificate from the Secretary of Labor indicating that you are eligible for trade readjustment allowance or alternative trade adjustment assistance under the Trade Act of 1974. The COBRA special second election period commences on the first day of the month in which a TAA Eligible employee begins to receive a trade readjustment allowance (or would have become eligible for such an allowance but for the requirements to exhaust unemployment compensation), or began to

receive alternative trade adjustment assistance, and ends after 60 days. In any event, the election must be made within six months after the initial loss of coverage that occurred in connection with the TAA Eligible employee's termination of employment. A TAA Eligible employee may also elect to continue coverage for their spouse and dependent children who are covered under the Plan as of the date of the TAA Eligible employee's termination of employment.

Flexible Spending Accounts
If you participated in CNH's flexible spending account, you may be entitled to continue under the health care flexible spending accounts by electing COBRA. Please contact CNH for more information regarding COBRA and your health care flexible spending account.

Termination of COBRA Coverage
COBRA coverage will terminate on the earliest of the following dates:

- The last day of the period for which you have made a timely payment in full;
- For a disability extension, the first of the month which is more than 30 days after the Social Security Administration determines that you are no longer disabled;
- The end of the month in which you first become covered, after electing COBRA, under another group health plan, provided the other coverage is not limited due to a preexisting condition limitation that applies to you;
- The end of the month in which you first become entitled to Medicare, after electing COBRA;
- The date CNH no longer offers group health coverage; or
- The date the Maximum Continuation Period expires.

Your COBRA coverage may also terminate for any reason that CNH would terminate the coverage of any non-COBRA participant or beneficiary, such as fraud.

Once COBRA coverage terminates, you lose all rights to continuation coverage and it cannot be reinstated.

When COBRA ends, you may have other options for health coverage as follows:

- If you take COBRA coverage for the maximum time available to you, you may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your COBRA coverage ends;
- If you take COBRA for the maximum time available to you, you may qualify for the right to purchase a guaranteed issue individual health insurance policy that does not impose a preexisting condition limitation. For more information, contact a health insurance agent;
- If no other coverage is available to you, you may qualify for your state's high risk health insurance plan. Contact your state's insurance department for further information.

If COBRA coverage is unavailable, you will receive a notice explaining why the Qualified Beneficiary is ineligible for continuation coverage. This notice is subject to the same timing requirements as an election notice.

If COBRA coverage will end before the Maximum Continuation Period, you will receive a notice as soon as administratively practicable after the termination decision is made. This notice will explain why and when COBRA coverage will terminate and will describe any rights available to you upon termination.

In order to protect your family's rights, you should keep CNH informed of any changes in the addresses of your family members. You should also keep a copy, for your records, of any notices you send to CNH.

In situations where CNH already provides continued coverage for all or part of the periods specified for a Qualified Beneficiary under COBRA, the period of continuation will include the month that CNH provides. For example, in the event of a lay off, if CNH continues group coverage for 12 months to the employee, the employee will be able to continue group coverage for an additional six months by paying the applicable COBRA contribution.

Special Age 65 Benefit and Continuation of the Group Benefits Plan After Retirement— Section J

Special Age 65 Benefit and Continuation of the Group Benefits Plan After Retirement—Section J

This Section J does not apply to individuals eligible for or receiving a pension benefit under the provisions for Deferred Vested Retirement under the CNH U.S. Pension Plan. This Section J also does not apply to surviving spouses receiving a spouse's pension resulting from a Deferred Vested Retirement or to any retiree who retired from CNH prior to December 1, 2004.

SPECIAL AGE 65 BENEFIT

The Special Age 65 Benefit (Medicare payment) shall be payable on behalf of you or your spouse if you are an active employee age 65 or older and both you and your spouse are covered by Medicare Part B. The Medicare payment shall be payable to you if you are a disabled employee who is eligible for Medicare during the period you are receiving Long Term Disability Benefits and Monthly Installment Life Insurance Benefits. If you are eligible for Medicare, you must provide CNH with proof of Medicare enrollment.

Amount of Medicare Payment

The Medicare payment shall be increased on the dates indicated:

• May 2004 – December 31, 2006	$65.50 or actual amount of Part B premium, if less
• January 1, 2007	$100 or actual amount of Part B and Part D premium, if less

In addition, the Medicare payment is payable on behalf of:

- employees who retired on a CNH -provided pension on or after December 1, 2004;
- The eligible spouse of a retired employee who retired on or after December 1, 2004; and
- The surviving spouse of an employee who retired on or after December 1, 2004, receiving a spouse's pension or who will receive a spouse's pension upon exhausting Survivor Income Benefits (Transition and Bridge).

You and your spouse are eligible to receive the Medicare payment if: (a) you retired on or after December 1, 2004 and (b) you and your spouse are enrolled in Medicare Part B (and effective January 1, 2007, Part D). The Medicare payment is not payable, however, if a Medicare repayment or reimbursement is being paid on behalf of you or your spouse from another source.

If the CNH-provided coverage is primary for you and your eligible dependents because you are an active employee or a disabled employee, CNH will not reimburse you or your dependent for the Medicare premium.

CONTINUATION OF THE GROUP BENEFITS PLAN AFTER RETIREMENT

Employees who retire under the CNH U.S. Pension Plan on or after December 1, 2004, or their surviving spouses shall be eligible for the group benefits as described in the following paragraphs. All other group benefits will cease coincident with the date of termination of employment due to retirement.

If you retire under the CNH U.S. Pension Plan with 10 or more years of service and are age 55 or over on your retirement date, you will be eligible to continue the group benefits shown below.

Life Insurance– Retired Employees Only (Including Disability Retirements)

Employees who retired on or after March 1, 2005

If you were hired prior to May 14, 1998, the life insurance benefit for your first year of retirement will be the same as your life insurance benefit level as an active employee. At the first anniversary of your retirement, the life insurance benefit level will be reduced by 50%. At the third anniversary of your retirement, the life insurance benefit will be terminated.

If you were hired after May 14, 1998, your life insurance benefit for your first year of retirement will be the same as it was when you were an active employee. At the first anniversary of your retirement, the life insurance benefit level will be reduced by 50%. At the third anniversary of your retirement, the life insurance benefit will be terminated.

Employees who retired on or after December 1, 2004 and before March 1, 2005

If you retired on a CNH-provided pension due to permanent and total disability, and the disability commenced after July 1, 1994, your life insurance benefit will continue in an unreduced amount until you attain age 65. At age 65, your life insurance benefit level will be reduced by 25%. At age 66, your life insurance benefit level will be reduced again by 25% of the original amount. Thereafter, you will have a life insurance benefit equal to 50% of your original active employee amount.

If you were hired prior to May 14, 1998, your life insurance benefit will continue in an unreduced amount until you attain age 65. At age 65, your life insurance benefit level will be reduced by 25%. At age 66, your life insurance benefit will be reduced again by 25% of the original amount. Thereafter, you will have a life insurance benefit equal to 50% of your original active employee amount.

If you were hired after May 14, 1998, you will have $7,500 of life insurance after you retire.

Group Health Care

The following benefits will apply to you and your surviving spouse if you retire on/or after the dates noted, are at least age 55 and have 10 years or more of service at your retirement date.

- Medical*
- Dental
- Vision

* Eligibility for specific coverage based on each benefit option's eligibility requirements.

You and your surviving spouse are not eligible for retiree health care coverage if you were hired after May 14, 1998.

If you were hired prior to May 14, 1998, you and your surviving spouse are eligible for retiree health care coverage only if you meet the following two requirements: (a) you retired on or after attaining age 55 and (b) you completed 10 or more years of service.

Enrollment

To continue the coverage described above, you and your surviving spouse must complete the required enrollment forms for each benefit and provide evidence of enrollment in Medicare Parts B and D, as required. If you or your surviving spouse are unable to enroll in Medicare Parts B and D because of an enrollment restriction, CNH will waive the Medicare enrollment requirement until your first opportunity to enroll in Medicare.

Contributions

CNH shall pay the contribution to continue your life insurance benefit. However, you and your surviving spouse are required to make contributions for continued health care coverage.

Claims Filing Procedures
Subrogation
General Plan Information and Statement of ERISA Rights—
Section K

Claims Filing Procedures
Subrogation
General Plan Information and
Statement of ERISA Rights—Section K

CLAIMS FILING PROCEDURES

CNH is responsible for the administration of the Plan's claims procedures. CNH has retained the services of Claims Administrators to provide professional claims adjudication services for the Plan.

In carrying out their respective responsibilities under the Plan. CNH and the insurance carrier of any fully insured benefits shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be final and binding, unless it can be shown that the interpretation or determination was arbitrary and capricious.

For the insured benefit components, the life insurance, accidental death and dismemberment and survivor income benefits, the insurance carrier will review the initial claim for benefits and will conduct any subsequent reviews of denied claims. For the self-funded benefit components, the medical/prescription drug, dental, vision and flexible spending accounts, the claims administrator for each particular benefit will review the initial claim for benefits and any intermediate-level appeal. CNH will conduct the final review.

Claims Denial and Appeal Procedures Applicable to Health Claims
The claims procedures below apply to the following benefits:

- Medical, Dental and Vision Benefits (including Prescription Drug benefits)
- Flexible Spending Accounts

A person entitled to benefits from the Plan must file an application for benefits as directed by the Plan for each of the above listed benefits.

The plan may make an adverse benefit determination of a claim for benefits in either written or electronic form. An adverse benefit determination includes any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan.

Time Limits on Decision of Claims

Urgent Care Claims

The Plan will inform the claimant of the decision on an Urgent Care claim as soon as possible, but not later than 72 hours after the claim was received by the Plan. If, during the review, additional information is required from the claimant, the claimant shall be so notified within 24 hours and shall be provided at least 48 hours to provide the information. In such a case, the Plan will inform the claimant of the decision as soon as possible, but not later than 48 hours after the additional information is submitted. Notification may be oral, unless written notification is requested by the claimant.

An Urgent Care claim is a claim for medical care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of the claimant or subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an Urgent Care claim shall be determined by the Plan, deferring to the judgment of a physician with knowledge of the claimant's condition.

Pre-Service Claims

The Plan will inform the claimant of the decision on a Pre-Service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days of the date the claim is received by the Plan, regardless of whether all necessary information was included with the claim. Within that 15-day period, the claimant shall receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 15-day benefit determination period, by which the claimant can expect to receive a decision. If a claimant fails to follow the procedures for filing a pre-service claim, the Plan will notify the claimant no later than five days following the failure. Notification may be oral, unless the claimant requests written notification. The notification is only required if the claimant files the improper claim with the person normally responsible for handling claim matters and the improper claim specifies (i) the name of the claimant, (ii) medical condition and (iii) treatment or service for which approval is requested.

If, during the review, additional information is required from the claimant, the claimant shall be so notified within the required time period for notice of a decision detailed above. The claimant shall have at least 45 days to provide such information after receiving the notice. Following the claimant's provision of the required information, or the expiration of the time period for providing such information, the Plan shall issue a written notice of the decision.

Alternatively, the notice of extension may include a notice of adverse benefit determination stating that the Plan will deny the claim if the claimant fails to provide any information in response to the Plan's request within a minimum of 45 days. In such case, the claimant may appeal the claim in accordance with the Plan's procedures. The notice shall further advise that the period for appealing the denied claim begins to run at the end of the deadline period set by the Plan. The notice must comply with the content requirements for the notification of adverse benefit determination as provided in subsection c of this section 6.3.

A Pre-Service claim is a claim for medical care or treatment with respect to which the Plan requires approval of the benefit in advance of obtaining medical care.

Post-Service Claims

The Plan will inform the claimant of the decision on a Post-Service claim within a reasonable period of time, but not later than 30 days of the date the claim is received by the Plan, regardless of whether all necessary information was included with the claim. Within that 30-day period, the claimant shall receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 30-day benefit determination period, by which the claimant can expect to receive a decision.

If, during the review, additional information is required from the claimant, the claimant shall be so notified within the required time period for notice of a decision detailed above. The claimant shall have at least 45 days to provide such information. Following the claimant's provision of the required information, or the expiration of the time period for providing such information, the Plan shall issue a written notice of the decision.

Alternatively, the notice of extension may include a notice of adverse benefit determination stating that the Plan will deny the claim if the claimant fails to provide any information in response to the Plan's request within a minimum of 45 days. In such case, the claimant may appeal the claim in accordance with the Plan's procedures. The notice shall further advise that the period for appealing the denied claim begins to run at the end of the deadline period set by the Plan. The notice must comply with the content requirements for the notification of adverse benefit determination

Concurrent Care Claims

Any request by a claimant to extend the duration or number of treatments previously approved through a Pre-Service claim is a Concurrent Care claim. The Plan will inform the claimant of the decision on a Concurrent Care claim involving Urgent Care within 24 hours after receiving the claim, whether adverse or not, if the claim was received by the Plan at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. The claimant may provide any additional information required to reach a decision. If the Concurrent Care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan will respond according to the type of claim involved (*i.e.*, Urgent, other Pre-Service or Post-Service).

Content of Denial Notice on a Claim

If a claimant's claim is partially or wholly denied, the claimant will receive a notice of adverse benefit determination. The notice will:

- State the specific reason or reasons for the adverse determination;
- Refer to specific Plan provisions on which the determination is based;
- Describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary;
- Describe the Plan's review procedures and the time limits applicable to such procedures.

- In the case of an adverse benefit determination by a group health plan concerning a claim for urgent care, describe the expedited review process applicable to such claims; and

- State the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

- As additional requirements, the notice will provide, if applicable, a copy of the internal rule, guideline or protocol that the Plan relied upon to make the adverse determination or state that a copy of such rule will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a determination of medical necessity or experimental treatment or a similar exclusion or limit, the notice will also provide either an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim -- How to Request a Review of a Denied Claim
If a claimant wants to have the denied claim reviewed, the claimant must send a written request for a review of the claim denial to the Plan no later than 180 days after receiving the claim denial. Any claimant filing a timely request for review may submit additional materials for consideration on review including a written explanation of the issues and comments on the issue. There will be no more than two levels of appeal.

Review of Denied Claim

- Full and Fair Review. A claimant who receives an adverse benefit determination of a claim shall be entitled to a full and fair review of the determination. The claimant may submit with the appeal written comments, documents, records, and other information relating to the claim for benefits. The claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. A document, record or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

  The Plan's review of the claim shall take into consideration all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan's determination on review shall be binding on all parties.

  As other requirements, the review on appeal will not defer to the initial adverse benefit determination. The review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual. If the adverse benefit determination is based in whole or in

part on a medical judgment, an appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Upon request, the Plan will provide the identification of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. The health care professional will not be the same professional who was consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. A health care professional is a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

In the case of a claim involving urgent care, the claims procedures will provide an expedited review process to which a request for appeal may be submitted orally or in writing. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

Time Limits on Review of Claims

Urgent Care Claims
The Plan will inform the claimant of the decision on the review of an Urgent Care claim as soon as possible, but not later than 72 hours of the Plan's receipt of the request for review.

Pre-Service Claims
The Plan will inform the claimant of the decision on the review of a Pre-Service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Plan's receipt of the request for review. If the Plan provides two levels of appeal, the notice will be provided, with respect to any one of such two appeals, not later than 15 days after the Plan's receipt of the claimant's request for review.

Post-Service Claims
The Plan will inform the claimant of the decision on the review of a Post-Service claim within a reasonable period of time, but not later than 60 days after the Plan's receipt of the request for review. If the Plan provides two levels of appeal, the notice will be provided, with respect to any one of such two appeals, not later than 30 days after the Plan's receipt of the claimant's request for review.

Concurrent Care Claims
The Plan will inform the claimant of the decision on the review of a Concurrent Care claim within 72 hours of the Plan's receipt of the request for review if the claim involves an Urgent Care claim; 30 days if the claim involves a Pre-Service claim; and 60 days if the claim involves a Post-Service claim.

Content of Denial Notice on Review
The notification of a determination on review will:

- State the specific reason or reasons for the adverse determination;

- Refer to specific Plan provisions on which the determination is based;

- State that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;

- State the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

The notification on review will also state if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and either provide a copy of the rule or state that a copy will be provided free of charge to the claimant upon request. If the adverse benefit determination is based on an exclusion or limit, the notification on review will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant free of charge upon request.

Deemed Exhaustion of Remedies
If the Plan fails to follow these procedures in accordance with applicable law, a claimant shall be deemed to have exhausted the administrative remedies available under the Plan. The claimant shall be entitled to pursue any available remedies under section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of a claim.

Authorized Representative of Claimant
The Plan's claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. The Plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the claimant. In the absence of contrary direction from the claimant, the Plan will direct all information and notifications to the representative authorized to act on the claimant's behalf.

Claims Denial and Appeal Procedures Applicable to Life Insurance and Survivor Income Claims
When a claim for Life Insurance or Survivor Income benefits is received, the following claim procedures will govern.

Notice and Proof of Claim
Sun Life Assurance Company of Canada ("Sun Life") must receive Notice and Proof of Claim prior to any payment.

- Notice of Death Claim. Written notice of claim must be given to Sun Life no later than 30 days after the date of death.

- Notice of Survivor Income Benefit Claim. Written notice of claim must be given to Sun Life no later than 30 days after the employee's date of death.

- Notice of Life Waiver of Premium. Written notice of claim must be given to Sun Life no later than 12 months after the employee ceases to be actively at work.

- Notice of Permanent Total Disability Income Benefit. Written notice of claim must be given to Sun Life no later than 12 months after the employee ceases to be actively at work.

If notice cannot be given within the applicable time period, Sun Life must be notified as soon as it is reasonably possible.

When Sun Life has received written notice of claim, Sun Life will send the forms for proof of claim. If the forms are not received within 15 days after written notice of claim is sent, proof of claim may be sent to Sun Life without waiting for the form.

- Proof of Death Claim. Proof of claim must be given to Sun Life no later than 90 days after date of death.

- Proof of Survivor Income Benefit Claim. Proof of claim must be given to Sun Life no later than 15 months after the Employee ceases to be actively at work.

- Proof of Life Waiver of Premium. Proof of claim must be given to Sun Life no later than 15 months after the Employee ceases to actively at work.

- Proof of Permanent Total Disability Income Benefit. Proof of claim must be given to Sun Life no later than 15 months after the Employee ceases to be actively at work.

If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required unless the individual is legally incompetent.

Proof of Claim must consist of a description of the loss or disability; the date the loss or disability occurred; and the cause of the loss or disability.

Proof of Claim may include, but is not limited to, police accident reports, autopsy reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials as appropriate for the disabling condition.

Proof must be satisfactory to Sun Life.

Sun Life may require as part of the Proof authorizations to obtain medical and non-medical information.

Proof of the employee's continued disability and regular and continuous care by a physician, a defined by Sun Life, must be given to Sun Life without 30 days of the request for proof.

Notice of Decision on Claim

A written notice of decision on a claim will be sent within a reasonably time after Sun Life receives the claim but not later than 34 days after receipt of the claim. If a decision cannot be made within 45 days after Sun Life receives the claim, Sun Life will request extensions of time

as permitted under U.S. Department of Labor regulations. Any request for extension of time will specifically explain:

1. the standards on which entitlement to benefits is based;
2. the unresolved issues that prevent a decision on the claim; and
3. the additional information needed to resolve those issues.

If a period of time I extended because the claimant failed to provide necessary information, the period for making the benefit determination is tolled from the date Sun Life sends notice of the extension to the claimant until the date on which the claimant responds to the request for additional information. The claimant will have at least 45 days to provide the specified information.

Review Procedure
If all of any part of a claim is denied, the claimant may request in writing a review of the denial within 180 days after receiving notice of denial.

The claimant may submit written comments, documents, records or other information relating to the claim for benefits, and may request free of charge copies of all documents, records and other information relevant to the claimant's claim for benefits.

Sun Life will review the claim on receipt of the written request for review, and will notify the claimant of Sun Life's decision within a reasonable time but no later than 45 days after the request has been received. If an extension of time is required to process the claim, Sun Life will notify the claimant in writing of the special circumstances requiring the extension and the date by which Sun Life expects to make a determination on review. The extension cannot exceed a period of 45 days from the end of the initial review period.

If a period of time is extended because the claimant failed to provide necessary information, the period for making the decision on review is tolled from the date Sun Life sends notice of the extension to the claimant until the date on which the claimant responds to the request for additional information.

Time of Payment of Claims
When Sun Life receives satisfactory Proof of Claim, benefits payable under this Policy will be paid for any period for which Sun Life is liable

Payment of Claims
Benefits payable upon the death of the employee are payable to the beneficiary living at the time (other than CNH). Unless otherwise specified, if more than one beneficiary survives the employee, all surviving beneficiaries will share equally.

If no beneficiary is alive on the date of the employee's death or the employee does not elect a beneficiary, Sun Life, at its option, may make payment as follows:

a. to the employee's spouse, if living; or
b. if there is no surviving spouse, to the employee's surviving children in equal shares; or

c. if there is no surviving spouse, children or parents, to the employee's surviving parents in equal shares; or
d. if there is no surviving spouse, children or parents, to the employee's surviving brothers and sisters in equal shares; or
e. if there is no surviving spouse, children or parents, brothers and sisters, to the employee's surviving grandparents in equal shares; or
f. if none of the above, to the employee's estate.

All other benefits payable during the lifetime of the employee are payable to the employee.

If a benefit is payable to the employee's estate who is a minor, or an employee who is not competent, Sun Life has the right to pay up to $5,000 to any of the employee's relatives whom Sun Life considered entitled. If Sun Life pays benefits in good faith to a good faith to a relative, Sun Life will not have to pay those benefits again.

Change of Beneficiary
Employees' nominations of beneficiaries under the plan will remain in force unless changed by the employee. All nominations of beneficiaries are revocable unless otherwise stated by the employee.

Any request for change of beneficiary must be in a written form and will take effect as of the date the employee signs and files the change with the employer. If Sun Life has taken any action or made payment prior to receiving notice of that change, the change of beneficiary will not affect any action or payment made by Sun Life. The consent of the beneficiary is not required to change any beneficiary unless the beneficiary designation has been irrevocable.

Claims Denial and Appeal Procedures Applicable to Accidental Death and Dismemberment Claims
When a claim for accidental death and dismemberment ("AD&D") benefits is received, the following claim procedures will govern.

Notice of Claim.

Written notice of the claim must be given to the American International Insurance Company of America ("American") within 20 days after your loss, or as soon thereafter as reasonably possible. Any notice given to American by you or on your behalf at American International Companies, Accident and Health Claims Division, 80 Pine Street, 13th Floor, New York, NY 10005, with information sufficient to identify you, is deemed notice to American.

Claim Forms

American will send claim forms to you upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, you will be deemed to have met the proof of loss requirements upon submitting, within the time for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include your name, your employer's name and the policy number, which you can obtain from your local benefits office.

Proof of Loss

Written proof of loss must be furnished to American within 90 days after the date of loss. If the loss is one that requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as American may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Payment of Claims

Upon receipt of due written proof of death, payment for your loss of life will be made to your beneficiary.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) you. If you die before all payments due have been made, the amount still payable will be paid to your beneficiary.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at American's option, to any relative by blood or connection by marriage of the payee, who, in American's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment American makes in good faith fully discharges American's liability to the extent of the payment made.

Time of Payment of Claims

Benefits payable for any loss other than loss for which this benefit provides any periodic payment will be paid immediately upon American's receipt of due written proof of the loss. Subject to American's receipt of due written proof of loss, all accrued benefits for loss for which this benefit provides periodic payment will be paid at the expiration of each month during the continuance of the period for which American is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

SUBROGATION

In the event of any payment of medical/hospital, dental or vision benefits under this Plan for which an employee, retiree, surviving spouse or a dependent ("You") may have a claim or cause of action against any person or organization (except a claim or cause of action against an employer and except against insurers of policies of insurance issued to, and in the name of the employee, retiree, surviving spouse, or dependent), CNH shall be subrogated to all right of Your recovery with respect to any expenses included in any judgment of settlement only to the extent that said judgment or settlement is expressly identified as a payment for medical/hospital, dental or vision services paid for under this Plan. If You incur attorney's fees in connection with the successful prosecution or settlement of any claim or cause of action which includes such benefits, CNH shall reduce its right of subrogation by a pro rata share of such attorney's fees

based on the ratio of the amount of any such medical/hospital, dental or vision benefits paid under this Plan to the total amount recovered by settlement of judgment. You must, at the request of CNH, execute and deliver such instruments and papers as may be required and to take such other reasonable steps necessary to secure the subrogation rights.

In cases where subrogation is involved, CNH will proportionately reduce its subrogation interest under the claims of its employees and their dependents when the actual amount recovered reflects less than the proper value of the case and a reasonable basis exists for accepting such lesser amount in settlement. A proper value of case is estimated by multiplying the financial loss (medical bills, lost time and property) by five.

To illustrate, assume a liability case has a value of $100,000, but a defendant has only $50,000 coverage and no other available assets, and that a settlement between the plaintiff and the defendant is reached for $50,000. Assume also that the monies expended by CNH for medical and hospital bills for the plaintiff employee or dependent totaled $10,000. If advised of these facts, and having ascertained their accuracy, CNH would proportionalize its subrogation interest and treat its original $10,000 amount expended as if it were only $5,000. Thus, to the same extent the employee or dependent is deprived of proper compensation for the injury (50% in this example), CNH also proportionalizes its subrogation interest (50%).

PLAN INFORMATION

Name of Plan

The CNH Employee Group Insurance Plan.

Type of Plan

The Plan is a group welfare benefit plan that provides self-funded medical, prescription drug, substance abuse and mental health, dental, vision, accidental death and dismemberment and disability benefits. The Plan also provides insured life insurance and survivor income benefits.

Plan Sponsor

Case New Holland Inc.
700 State Street
Racine, WI 53404

Plan Administrator

Plan Administrator
CNH Employee Group Insurance Plan
CNH Benefits Committee
700 State Street
Racine, WI 53404
262-636-6011

Identification Numbers

CNH's federal employer identification number is 39-1982756. The plan number assigned to the Plan is 652.

Agent for Service of Legal Process

If legal disputes involving the Plan arise, any legal documents should be served upon:

Plan Administrator
CNH Employee Group Insurance Plan
CNH Benefits Committee
700 State Street
Racine, WI 53404

If the dispute involves a claim for life insurance or survivor income benefits, additional service of legal process must be made upon the insurer at one of its local offices, or upon the supervisory official of the Department of Insurance in the state in which you reside. The respective insurers for the life insurance, accidental death and dismemberment and survivor income benefits are:

Life Insurance and Survivor Income Benefits

Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481
1-800-247-6875

Accidental Death and Dismemberment Benefits

American International Insurance Company of America
70 Pine Street
New York, NY 10270
212-770-7000

Collective Bargaining Agreement

The Plan is maintained, in part, pursuant to a collective bargaining agreement. Plan participants and beneficiaries may examine this collective bargaining agreement and may obtain a copy of any such agreement for a reasonable charge by writing to the Plan Administrator.

Funding Method

The Plan's benefits for eligible Employees are provided through employee and employer contributions. The amounts of the employee and employer contributions are determined by the provisions of the collective bargaining agreement. Employee contributions are the first source of funds used to pay benefits.

Plan Year

The Plan Year begins January 1 and ends on the next following December 31.

Source of Contributions

All benefits except the Life Insurance and Survivor Income Benefits (Transition and Bridge) are self-funded. The self-funded benefits are paid from Plan assets that are held in trust and are used exclusively to provide benefits to participants and defray reasonable administrative expenses.

The Life Insurance and Survivor Income Benefits (Transition and Bridge) are fully insured.

Type of Administration

CNH is the named fiduciary of the Plan and the Plan Administrator with authority to control and manage the operation and administration of the Plan. The Plan Administrator has the full power to administer the Plan in all of its details, subject to the applicable requirements of law. Except to the extent delegated, the Plan Administrator has the discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with its review of claims under the Plan. Such discretionary authority is intended to include, but is not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the Plan, the determination of whether a person is entitled to benefits under the Plan and the computation of any and all benefit payments. The Plan Administrator has the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial that has been appealed by the claimant.

The Plan Administrator may amend the plan at any time and from time to time consistent with the collective bargaining agreement. An amendment or termination of the plan may affect not only the coverage of active employees (and their covered dependents) but also of COBRA continues and former employees who retired, died, or otherwise terminated employment.

For the self-funded benefits, the Plan Administrator has engaged the services of the following claims administrators to perform the day to day claims administration of the Plan. The claims administrator shall be named claims fiduciary within the meaning of ERISA only to the extent the administrative services agreement delegates to the claims administrator discretion with respect to determining a participant's claim for benefits.

Medical & Flexible Spending Accounts

Fiserv Health - Wausau Benefits
115 West Wausau Avenue
Wausau, WI 54402
1-800-826-9781

Prescription Drug

Walgreen's Health Initiatives
P.O. Box 545
Deerfield, IL 60015
1-800-207-2568

Dental

Delta Dental Plan of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
1-800-236-3712

Vision

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, CA 95670
1-800-622-7444

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Fund participants shall be entitled to:

Receive Information About Your Fund and Benefits
Examine, without charge, at your local benefits office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration).

Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Coverage
Continue coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description (or "SPD") and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to

24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including CNH, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time frames.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

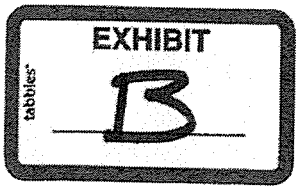
Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MW/1290257

CNH Health and Welfare Plan

As Amended and Restated Effective January 1, 2009



CNH Health and Welfare Plan

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ARTICLE I

THE PLAN AND DEFINITIONS

1.1 **The Plan.** This document, together with the Appendices, constitutes the entire Plan and is the official Plan document that describes and incorporates the Benefit Components that are described in separate documents. The Plan Sponsor maintains this Plan for the benefit of an Employer's eligible Employees and their dependents. A Participant's rights under the Plan are legally enforceable.

1.2 **Definitions.** The following words and phrases shall have the meanings stated below:

(a) Administrative Services Agreement. An agreement, other than an Insurance Contract, entered into by the Plan Sponsor and an Administrative Services Organization to perform certain administrative services for the Plan or a Benefit Component that is part of the Plan.

(b) Administrative Services Organization ("ASO"). An entity that regularly engages in the business of managing health care services, and/or providing claims administration, adjustment and payment, utilization management, and/or claims review services to employee welfare benefit plans other than through an Insurance Contract.

(c) Appendix or Appendices. The Appendices located at the end of the Plan. Each Appendix shall be considered a part of the Plan and shall be subject to the terms of the Plan.

(d) Applicable Law. The Internal Revenue Code of 1986, as amended (the "Code"), the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and any other law of a state or the United States which may apply to the Plan or any Benefit Component, and regulations promulgated thereunder.

(e) Benefit Component. A written benefit program maintained by the Plan Sponsor to provide health and welfare benefits to an Employer's eligible Employees and Eligible Dependents. Such Benefit Components are referenced in Appendix I, and specifically are incorporated into the Plan by this reference. All Summary Plan Descriptions, insurance certificates, contracts and other documents relating to Benefit Components are incorporated into the Plan by this reference. Each Benefit Component is governed by its terms. The terms of a Benefit Component that are provided through insurance contracts shall prevail in the case of any conflict between this Plan document and such Benefit Component. The Plan document shall prevail in all other circumstances.

(f) Carrier. A company entering into an Insurance Contract with the Plan Sponsor pursuant to the Plan.

(g) Claims Administrator. A Carrier or an ASO retained by the Plan Sponsor to determine benefit eligibility and to adjudicate claims under one or more Benefit Components.

(h) Eligible Dependent. A dependent of an eligible Employee who is identified in one or more Benefit Components as eligible to participate in such Benefit Component(s).

(i) Employee. An individual (including a retiree) employed or formerly employed as a common law employee of an Employer and who is identified in one or more Benefit Components as eligible to participate in such Benefit Component(s).

(j) Employer(s). The Participating Employers who adopt into the Plan as set forth in Appendix II to this Plan.

(k) Insurance Contract. An agreement entered into by the Plan Sponsor or Committee and a Carrier with respect to insured benefits provided under a Benefit Component.

(l) Participant. An eligible Employee or Eligible Dependent who participates in at least one Benefit Component.

(m) Plan. The CNH Health and Welfare Plan as set forth herein and in the Benefit Components, and as such Plan may be amended from time to time.

(n) Plan Administrator. The Plan Sponsor, which shall control and manage the operation and administration of the Plan as the named fiduciary. In accordance with Article V, the Plan Sponsor may authorize an individual, or group of individuals, to act as Plan Administrator on its behalf.

(o) Plan Sponsor. Case New Holland Inc. and any successor thereto.

(p) Summary Plan Description ("SPD"). The employee communication document designated as a SPD, which describes the benefits provided under a Benefit Component.

ARTICLE II

PARTICIPATION

2.1 **Eligibility.** The terms and conditions for eligibility to participate and procedures for enrollment for each benefit provided under the Plan, as well as the period during which participation with respect to such benefit continues, shall be set forth in the applicable Benefit Component(s) described in Appendix I as they may be modified from time to time by subsequent amendments. Participation in the Plan commences when an Employee first becomes covered for a benefit under any Benefit Component. To the extent not set forth in the Plan, any restrictions, limitations and additional requirements relating to a Participant's entitlement to benefits are described in the Benefit Component(s).

2.2 **Medicaid Provisions.** As required by ERISA section 609(b):

(a) This Plan will not take into account the fact that any Employee is eligible for or is provided medical assistance by Medicaid, for purposes of determining eligibility or benefits under this Plan.

(b) In payment of its benefits, this Plan will honor any Medicaid assignment of rights made by or on behalf of any Participant.

(c) This Plan will honor any reimbursement or subrogation rights that a state may have be virtue of payment of Medicaid benefits for expenses covered by this Plan.

ARTICLE III

BENEFITS

3.1 **Description of Plan Benefits.** Benefits provided under the Plan are set forth in the Benefit Components, as such documents may be modified from time to time by subsequent amendments. Each eligible Employee may elect to receive coverage under one or more of the benefit coverages for himself and for his Eligible Dependents, as provided in the Benefit Components. The terms, conditions and limitations of benefits offered under this Plan are contained in the applicable Benefit Components. The insurer, contract number, or funding method of providing certain benefits may change from time to time and shall be reflected in the applicable Benefit Components.

3.2 **Limitation on Plan Benefits.** To the extent the Plan provides any benefits which are considered "excess benefits" under section 105(h)(7) of the Code, an Employer shall consider such benefits to be taxable income to the affected highly compensated employee, and such benefits shall not be treated as being made from this Plan. In no event shall benefits be paid in excess of the limitations contained in a Benefit Component.

ARTICLE IV

FUNDING

4.1 **Employer Contributions.** Subject to section 5.9 of the Plan, Right to Amend or Terminate, benefits under the Plan shall be funded in whole or in part by Employer contributions as the Plan Sponsor shall determine from time to time. Such contributions shall be made at the times and in the manner, as the Plan Sponsor shall determine. All such contributions shall be used for the exclusive purpose of providing benefits to Participants. In no event shall the Employer have any obligation to fund uninsured benefits under the Plan in advance of the date that such benefits are payable. The amount of such Employer contributions shall be determined in accordance with applicable personnel or employment arrangements (including any applicable collective bargaining agreements) and any applicable budgetary limitations as determined by the appropriate officers of the Plan Sponsor, based on the following:

(a) The actuarially determined liability required to provide the various benefits for Participants under the Plan;

(b) The fees and expenses of a Carrier or an ASO for the provision of benefits and performance of their respective duties under the Plan;

(c) Administrative and other expenses of the Plan, including expenses incurred by the Plan Administrator in the performance of its duties under the Plan and including reasonable compensation for legal counsel, certified public accountants, actuaries, consultants, and agents, and the cost of other services rendered with respect to the Plan;

(d) The benefits due and owing under the Plan in accordance with the Benefit Components; and

(e) All other proper charges and disbursements of the Plan Administrator including settlements of claims or legal actions approved by counsel to the Plan, as shall be determined by the Plan Administrator.

4.2 **Employee Contributions.** Each eligible Employee participating in the Plan shall pay contributions for participation in the Plan as specified by the Plan Sponsor. The amount of contributions shall be determined by the Plan Sponsor and communicated to Employees from time to time. The amount of contributions with respect to each Benefit Component shall depend on the type(s) of coverage elected by the Employee under the Plan, and the number of individuals the Employee elects to cover (e.g., single coverage or family coverage).

4.3 Sources of Benefits.

(a) Self-Funded Benefits. The Plan Sponsor established the CNH Health and Welfare Trust (the "Trust"), which shall be the sole source of self-funded benefits under the Plan, except for Short-Term Disability benefits which shall be funded solely from the Plan Sponsor's general assets. To the maximum extent permitted by ERISA and any other applicable law, the Plan Sponsor assumes no liability or responsibility for payment of such benefits beyond that which is provided in this Plan and the Trust, and each Participant or other person who claims the right to any payment with respect to such benefits under the Plan shall not have any right, claim or demand therefore against the Plan Sponsor, any officer or director of the Plan Sponsor, the Plan Administrator, or any committee member thereof, an Employer, or any employee, officer or director of the Employer.

(b) Insured Benefits. With respect to insured benefits, the insurance premiums are paid through the Trust. A Participant (or in the case of the death of a Participant, his or her beneficiary as that term is defined in the applicable Benefit Component) shall be entitled to receive only the insured benefits for which provision is actually made under an Insurance Contract, and the Plan Sponsor assumes no liability or responsibility for any insured benefits. To the maximum extent consistent with ERISA, the Insurance Contracts shall be the governing documents and the sole source of insured benefits, and each Participant shall be entitled to look only to the Insurance Contracts for payment of any such benefit and shall not have any rights, claim or demand therefore against the Plan Sponsor, any officer or director of the Plan Sponsor, the Plan Administrator, or any committee member thereof, an Employer, or any employee, officer or director of an Employer. To the maximum extent consistent with ERISA or other applicable law, in the event of a conflict between the terms of an Insurance Contract and the Plan or an SPD, the terms of the Insurance Contract shall govern.

ARTICLE V

PLAN ADMINISTRATION, AMENDMENT AND TERMINATION

5.1 **Administrative and Fiduciary Responsibilities.** The Plan Sponsor is a named fiduciary with discretionary authority to control and manage the operation and administration of the Plan. Notwithstanding the foregoing, any Carrier or ASO shall be solely responsible with respect to the matters for which it is made responsible under its Insurance Contract or Administrative Services Agreement, including fiduciary responsibilities, and to the extent required by ERISA.

The Plan Sponsor may appoint a separate Plan Administrator. Any person, including, but not limited to, Employees of an Employer, shall be eligible to serve as Plan Administrator. Two or more persons may be appointed to form a committee to serve as Plan Administrator. Persons serving as Plan Administrator may resign by written notice to the Plan Sponsor or the Plan Sponsor may remove such persons. A Plan Administrator consisting of more than one person shall act by a majority of its members at the time in office, either by vote at a meeting or in writing without a meeting. A Plan Administrator consisting of more than one person may authorize any one or more of its members to execute any document or documents on behalf of the Plan Administrator, in which event the Plan Administrator shall notify the Plan Sponsor of the member or members so designated. The Plan Sponsor shall accept and rely upon any document executed by such member or members as representing action by the Plan Administrator until the Plan Administrator shall file with the Plan Sponsor a written revocation of such designation. No person serving as Plan Administrator shall vote or decide upon any matter relating solely to himself or solely to any of his rights or benefits pursuant to the Plan. If the Plan Sponsor fails to appoint a Plan Administrator, the Plan Sponsor shall be the Plan Administrator.

In administering the Plan, the Plan Sponsor shall at all times discharge its duties with respect to the Plan in accordance with the standards set forth in section 404(a)(1) of ERISA. The Plan Sponsor will carry out its duties and responsibilities under the Plan through any individual or committee appointed to serve as Plan Administrator and through the Plan Sponsor's board of directors and officers, acting on behalf of and in the name of the Plan Sponsor in their capacities as directors and officers and not as individual fiduciaries.

5.2 **Allocation of Fiduciary Responsibilities.** In exercising their fiduciary responsibilities, the named fiduciaries shall have the discretionary authority described below. Each named fiduciary shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily or capriciously.

(a) Except to the extent that such duties have been delegated to an ASO under an Administrative Services Agreement, the Plan Administrator shall have sole discretionary authority with respect to determining a Participant's

claim for benefits under the Plan's self-insured benefits as provided in the applicable Benefit Components, including but not limited to determining eligibility to participate, rendering final determinations regarding medical necessity and determining and authorizing payment of benefits. With respect to insured benefits described in the applicable Benefit Components, the Plan Administrator shall have no discretionary authority except to the extent granted by a Carrier with respect to performing certain administrative functions, such as determining eligibility for participation and enrolling eligible individuals in accordance with the terms and conditions of the Insurance Contract issued in connection with the applicable Benefit Component.

(b) Each ASO shall be a named claims fiduciary, within the meaning of ERISA, only to the extent the Administrative Services Agreement delegates to the ASO discretion with respect to determining a Participant's claim for benefits under the Plan's self-insured benefits, including but not limited to determining eligibility to participate, determining and authorizing payment of benefits in accordance with the Plan and the Administrative Services Agreement and rendering final determinations regarding medical necessity, as provided in the applicable Benefit Component.

(c) Each Carrier shall be a named claims fiduciary, within the meaning of ERISA and shall have sole discretion with respect to the Plan's insured benefits described in an Insurance Contract included in a Benefit Component, to determine eligibility for participation, coverage, payment of benefits and all such other determinations set forth in the governing Insurance Contract and this Plan. Neither the Plan Sponsor nor the Plan Administrator shall have any liability or responsibility for any insured benefits beyond the payment of premiums as set forth in the Insurance Contract.

5.3 **Duties of the Plan Administrator.** The Plan Administrator shall have the general day-to-day responsibility for the administration of the Plan, except to the extent that such responsibility has been delegated to an ASO or Carrier as described above. The Plan Administrator shall make such rules, regulations, computations and interpretations of the Plan, perform any act that the Plan Sponsor could perform with respect to an Insurance Contract issued in connection with the Plan, comply with reporting and disclosure requirements of ERISA, establish and maintain Plan records, have sole discretion to determine the eligibility of individuals for benefits pursuant to the objective criteria set forth in the Plan, determine and authorize payment of benefits and take any other action to administer the Plan as the Plan Administrator may deem appropriate in its sole discretion. The Plan Administrator shall be deemed to have properly exercised its authority unless it has abused its discretion by acting arbitrarily or capriciously. The rules, interpretations, computations and actions of the Plan Administrator

shall be conclusive and binding on all persons. The Plan Administrator may engage Carriers or ASOs to perform specified administrative services for the Plan and shall review such Carriers' activities under the Plan, and may also engage actuaries, accountants, attorneys and consultants, as it deems necessary or advisable for purposes of the Plan.

5.4 **Delegation of Administrative Duties.** The Plan Administrator may make use of such agents and clerical or other personnel, as it deems necessary or advisable for purposes of the Plan. The Plan Administrator may rely upon the actions of the Carrier or ASO or the written opinion or advice of counsel or any actuary or accountant engaged by the Plan Administrator. Furthermore, the Plan Administrator may delegate to any such agent or to any other person, authority to perform any act hereunder, including, without limitation, those matters involving the exercise of discretion; provided, however, that such delegation shall be subject to revocation at any time at the discretion of the Plan Administrator.

5.5 **Expenses.** Unless specified otherwise in a Benefit Component, all reasonable expenses, which are necessary to operate and administer the Plan, shall be paid by the Plan, unless the Plan Sponsor elects to pay such expenses.

5.6 **Reports and Records Retention.** The Plan Administrator shall file or cause to be filed all annual reports, returns, and financial and other statements required by any federal or state statute, agency or authority within the time prescribed by law or regulation for filing said documents; and to furnish such reports, statements or other documents to such Participants and beneficiaries as required by federal or state statute or regulation, within the time prescribed for furnishing such documents. The Plan Administrator shall maintain records that relate to the performance of its activities for a minimum of six years or for such longer period as may be required by ERISA or other Applicable Law.

5.7 **Bonding and Insurance.** To the extent required by law, with respect to benefits subject to ERISA, every fiduciary of the Plan and every person handling Plan funds shall be bonded. The Plan Administrator shall take such steps as are necessary to assure compliance with applicable bonding requirements. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility at the Plan's expense, and insuring the Plan Administrator against all liabilities, damages, costs and expenses incurred by any good faith act or omission in connection with the Plan.

5.8 **Right of Recovery.** If the Plan has made an erroneous or excess payment to or on behalf of any Participant, the Plan Administrator shall be entitled to recover such excess from the Participant to whom or on behalf of whom such payments were made. Where family members of the Participant are also covered by the Plan, recovery may also be made from benefits that would otherwise be payable to or on behalf of such other family members. The recovery of such erroneous or excess payment may be made by any of the methods specified for subrogation and

reimbursement under Article VIII of the Plan, including the imposition of a constructive trust, or by offsetting the amount of any other benefit or amount payable to the Participant by the amount of the excess payment under the Plan, to the extent permitted by Applicable Law.

5.9 **Right to Amend or Terminate.** The Plan is maintained for the exclusive benefit of Participants with the intention that it be maintained for an indefinite period of time. The Plan Sponsor intends that each Participant's rights under the terms of the Plan be legally enforceable. The Plan Sponsor, however, reserves the right to amend or terminate any part or all of the Plan at any time. For example, the Plan Sponsor reserves the right to amend or terminate covered expenses, benefit co-payments, deductibles and lifetime maximums, and reserves the right to amend the Plan to require or increase contributions by Participants. The Plan Sponsor also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable and to amend or terminate any and all health care or other benefits provided under the Plan. Nothing in this Plan shall be construed to require continuation of the Plan with respect to existing or future Participants or their beneficiaries.

5.10 **Procedure for Amendment or Termination.** Any such amendment or termination, or other action by the Plan Sponsor, shall be by a duly adopted resolution of the board of directors or by any person or persons duly authorized by a duly adopted resolution of the board of directors to take such action on behalf of the board of directors.

Any Participating Employer that has adopted this Plan with the approval of the board of directors shall be deemed, by continuing participation in the Plan, to accept any such action by or on behalf of the board of directors or the Plan Administrator. In addition, the board of directors of each Participating Employer reserves the right to terminate such Employer's participation in the Plan.

In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan shall terminate unless the Plan is continued by a successor to the Plan Sponsor.

ARTICLE VI

CLAIMS PROCEDURES

6.1 **Claims for Benefits**. The claims procedures specified in the document describing a specific benefit shall apply unless:

(a) The document does not contain a procedure; or

(b) The procedures do not comply with legal requirements.

If either of those circumstances exist, the procedures stated in this Article 6 shall apply.

6.2 **Administration of Claims Procedures**. The Plan Administrator is responsible for the administration of the Plan's claims procedures, which are described in sections 6.3 and 6.4. The Plan Administrator has retained the services of Claims Administrators to provide professional claims adjudication services for the Plan.

In carrying out their respective responsibilities under the Plan, the Plan Administrator and the insurance Carrier of any fully insured benefits shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be final and binding, unless it can be shown that the interpretation or determination was arbitrary and capricious.

For insured Benefit Components, the Carrier will review the initial claim for benefits and will conduct any subsequent reviews of denied claims. For self-funded Benefit Components that are subject to an Administrative Services Agreement, the Claims Administrator will review the initial claim for benefits. If the underlying agreement designates more than one review, the Plan Administrator will conduct the final review. If the agreement specifies only one level of review, the Plan Administrator will conduct the review of denied claims. For self-funded, self-administered Benefit Components, the Plan Administrator will review the initial claim for benefits and will conduct any subsequent reviews of denied claims.

6.3 **Claims Denial and Appeal Procedures Applicable to Group Health and Disability Claims.** The claims procedures in this section 6.3 apply to the following Benefit Components:

Medical, Dental and Vision Benefits (including Prescription Drug benefits)

Health Care Flexible Spending Accounts

Disability Benefits

Effective on January 1, 2003, the following claims procedures shall govern the filing of benefit claims, notification of benefit determinations and appeal of adverse benefit determinations. A description of these procedures is included the Summary Plan Descriptions. If there are any inconsistencies between these procedures and the SPDs, these procedures shall control. These procedures shall not be construed in any manner that would unduly inhibit or hamper the initiation or processing of any claim for benefits. All benefit determinations made pursuant to these procedures shall be made in accordance with the documents governing the Plan and, where appropriate, shall be applied consistently with respect to similarly situated claimants. These claims procedures are intended to comply with section 503 of ERISA, the Department of Labor ("DOL") regulations thereunder and DOL interpretations of such regulations.

(a) Application and Adverse Determination of Benefits. A person entitled to benefits from the Plan must file an application for benefits as directed by the Plan for each of the above listed benefits. The Plan's approval or denial of the claim shall be processed in accordance with the individual SPDs and these procedures.

The Plan may make an adverse benefit determination of a claim for benefits in either written or electronic form. An adverse benefit determination includes any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan.

(b) Time Limits on Decision of Claims.

(1) Health Claims.

[a] Urgent Care Claims. The Plan will inform the claimant of the decision on an Urgent Care claim as soon as possible, but not later than 72 hours after the claim was received by the Plan. If, during the review, additional information is required from the claimant, the claimant shall be so notified within 24 hours and shall be provided at least 48 hours to provide the information. In such a case, the Plan will inform the claimant of the decision as soon as possible, but not later than 48 hours after the additional information is submitted. Notification may be oral, unless written notification is requested by the claimant.

An Urgent Care claim is a claim for medical care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of the claimant or subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an Urgent Care claim shall be determined by the Plan, deferring to the judgment of a physician with knowledge of the claimant's condition.

[b] Pre-Service Claims. The Plan will inform the claimant of the decision on a Pre-Service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days of the date the claim is received by the Plan, regardless of whether all necessary information was included with the claim. Within that 15-day period, the claimant shall receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 15-day benefit determination period, by which the claimant can expect to receive a decision. If a claimant fails to follow the procedures for filing a pre-service claim, the Plan will notify the claimant no later than five days following the failure. Notification may be oral, unless the claimant requests written notification. The notification is only required if the claimant files the improper claim with the person normally responsible for handling claim matters and the improper claim specifies (i) the name of the claimant, (ii) medical condition and (iii) treatment or service for which approval is requested.

If, during the review, additional information is required from the claimant, the claimant shall be so notified within the required time period for notice of a decision detailed above. The claimant shall have at least 45 days to provide such information after receiving the notice. Following the claimant's provision of the required information, or the expiration of the time period for providing such information, the Plan shall issue a written notice of the decision.

Alternatively, the notice of extension may include a notice of adverse benefit determination stating that the Plan will deny the claim if the claimant fails to provide any information in response to the Plan's request within a minimum of 45 days. In such case, the claimant may

appeal the claim in accordance with the Plan's procedures. The notice shall further advise that the period for appealing the denied claim begins to run at the end of the deadline period set by the Plan. The notice must comply with the content requirements for the notification of adverse benefit determination as provided in subsection c of this section 6.3.

A Pre-Service claim is a claim for medical care or treatment with respect to which the Plan requires approval of the benefit in advance of obtaining medical care.

[c] Post-Service Claims. The Plan will inform the claimant of the decision on a Post-Service claim within a reasonable period of time, but not later than 30 days of the date the claim is received by the Plan, regardless of whether all necessary information was included with the claim. Within that 30-day period, the claimant shall receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 30-day benefit determination period, by which the claimant can expect to receive a decision.

If, during the review, additional information is required from the claimant, the claimant shall be so notified within the required time period for notice of a decision detailed above. The claimant shall have at least 45 days to provide such information. Following the claimant's provision of the required information, or the expiration of the time period for providing such information, the Plan shall issue a written notice of the decision.

Alternatively, the notice of extension may include a notice of adverse benefit determination stating that the Plan will deny the claim if the claimant fails to provide any information in response to the Plan's request within a minimum of 45 days. In such case, the claimant may appeal the claim in accordance with the Plan's procedures. The notice shall further advise that the period for appealing the denied claim begins to run at the end of the deadline period set by the Plan. The notice must comply with the content requirements for the notification of adverse benefit determination.

[d] Concurrent Care Claims. Any request by a claimant to extend the duration or number of treatments previously approved through a Pre-Service claim is a Concurrent Care claim. The Plan will inform the claimant of the decision on a Concurrent Care claim involving Urgent Care within 24 hours after receiving the claim, whether adverse or not, if the claim was received by the Plan at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. The claimant may provide any additional information required to reach a decision. If the Concurrent Care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan will respond according to the type of claim involved (i.e., Urgent, other Pre-Service or Post-Service).

(2) Disability Benefit Claims. If a claim for disability benefits is denied in whole or in part, the Plan will inform the claimant of the denial within a reasonable period of time, but not later than 45 days of the date the initial claim was received, regardless of whether all necessary information was included with the claim.

[a] Extension. Special circumstances may require more time to review a claim. If so, written notice shall be provided within the 45-day period explaining the reason for the delay and setting a date upon which the notice will be issued, no later than 30 days after the end of the initial 45-day benefit determination period. If special circumstances again require more time to review a claim, a second 30-day extension may be taken subject to written notice within the initial 30-day extension, subject to the same rules as detailed above.

[b] Additional Information. If, during the review, additional information is required from the claimant, the claimant shall be so notified within the required time periods for notice of a decision or extension detailed above. The claimant shall have at least 45 days to provide such information after receiving the notice. Following the claimant's provision of the required information, or the expiration of the time period for providing such information, the Plan shall issue a written notice of any denial within 30 days, unless special circumstances require a second 30-day extension, subject to the rules detailed above.

Alternatively, the notice of extension may include a notice of adverse benefit determination stating that the Plan will deny the claim if the claimant fails to provide any information in response to the Plan's request within a minimum of 45 days. In such case, the claimant may appeal the claim in accordance with the Plan's procedures. The notice shall further advise that the period for appealing the denied claim begins to run at the end of the deadline period set by the Plan. The notice must comply with the content requirements for the notification of adverse benefit determination as described in subsection c of this section 6.3.

(c) Content of Denial Notice on a Claim. If a claimant's claim is partially or wholly denied, the claimant will receive a notice of adverse benefit determination. The notice will:

(1) State the specific reason or reasons for the adverse determination;

(2) Refer to specific Plan provisions on which the determination is based;

(3) Describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary;

(4) Describe the Plan's review procedures and the time limits applicable to such procedures;

(5) In the case of an adverse benefit determination by a group health plan concerning a claim for urgent care, describe the expedited review process applicable to such claims; and

(6) State the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

As additional requirements, the notice will provide, if applicable, a copy of the internal rule, guideline or protocol that the Plan relied upon to make the adverse determination or state that a copy of such rule will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a determination of medical necessity or experimental treatment or a similar exclusion or limit, the notice will also provide either an explanation of the scientific or clinical judgment for the

determination that applies the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(d) Appeal of Denied Claim -- How to Request a Review of a Denied Claim. If a claimant wants to have the denied claim reviewed, the claimant must send a written request for a review of the claim denial to the Plan no later than 180 days after receiving the claim denial. Any claimant filing a timely request for review may submit additional materials for consideration on review including a written explanation of the issues and comments on the issue. There will be no more than two levels of appeal.

(e) Review of Denied Claim.

(1) Full and Fair Review. A claimant who receives an adverse benefit determination of a claim shall be entitled to a full and fair review of the determination. The claimant may submit with the appeal written comments, documents, records, and other information relating to the claim for benefits. The claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. A document, record or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The Plan's review of the claim shall take into consideration all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan's determination on review shall be binding on all parties.

As other requirements, the review on appeal will not defer to the initial adverse benefit determination. The review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit

determination nor the subordinate of such individual. If the adverse benefit determination is based in whole or in part on a medical judgment, an appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Upon request, the Plan will provide the identification of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. The health care professional will not be the same professional who was consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. A health care professional is a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

In the case of a claim involving urgent care, the claims procedures will provide an expedited review process to which a request for appeal may be submitted orally or in writing. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

(2) Time of Decision.

[a] Urgent Care Claims. The Plan will inform the claimant of the decision on the review of an Urgent Care claim as soon as possible, but not later than 72 hours of the Plan's receipt of the request for review.

[b] Pre-Service Claims. The Plan will inform the claimant of the decision on the review of a Pre-Service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Plan's receipt of the request for review. If the Plan provides two levels of appeal, the notice will be provided, with respect to any one of such two appeals, not later than 15 days after the Plan's receipt of the claimant's request for review.

[c] Post-Service Claims. The Plan will inform the claimant of the decision on the review of a Post-Service claim within a reasonable period of time, but not later than 60 days after the Plan's receipt of the request for review. If the Plan provides two levels of appeal, the notice will be provided,

with respect to any one of such two appeals, not later than 30 days after the Plan's receipt of the claimant's request for review.

[d] Concurrent Care Claims. The Plan will inform the claimant of the decision on the review of a Concurrent Care claim within 72 hours of the Plan's receipt of the request for review if the claim involves an Urgent Care claim; 30 days if the claim involves a Pre-Service claim; and 60 days if the claim involves a Post-Service claim.

[e] Disability Benefits. The Plan will inform the claimant of the decision on review of a Disability claim within a reasonable period of time, but not later than 45 days after receipt of the claimant's request for review by the Plan. The Plan may determine that an extension of time for processing the claim is required. If an extension is required, the Plan shall provide notice of the extension to the claimant before the end of the initial 45-day period. The notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. The extension of the determination on review shall not exceed a period of 45 days from the end of the initial period.

(3) Content of Denial Notice on Review. The notification of a determination on review will:

[a] State the specific reasons or reasons for the adverse determination;

[b] Refer to the specific Plan provisions on which the benefit determination is based;

[c] State that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and

[d] State the claimant's right to bring an action under section 502(a) of ERISA.

The notification on review will also state if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and either provide a copy of the rule or state that a copy will be

provided free of charge to the claimant upon request. If the adverse benefit determination is based on an exclusion or limit, the notification on review will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant free of charge upon request.

6.4 **Accidental Death and Dismemberment, Life Insurance and Survivor Income Benefits**. When a claim for an Accidental Death and Dismemberment ("AD&D"), Life Insurance or Survivor Income benefits is received, the claim procedures of the insurance contract will govern, except to the extent that they prevent the application the general claims procedures specified as follows:

(a) Time Limits on Decision of Claims. Unless special circumstances exist, the Plan will inform the claimant of the Plan's decision on an AD&D, Life Insurance or Survivor Income benefits claim within 90 days of the date the claim is filed, regardless of whether all the information and evidence necessary to process the claim is received. Within such 90-day period, the claimant will receive a notice of the Plan's decision or a notice that:

(1) Explains the special circumstances requiring a delay in the decision; and

(2) Sets a date, no later than 180 days after the claim has been received, by which the claimant can expect to receive a decision.

(b) Content of a Denial Notice on a Claim. If a claim for AD&D, Life Insurance or Survivor Income benefits is partially or wholly denied, the claimant will receive a notice of adverse benefit determination. The notice will:

(1) State the specific reason or reasons for the adverse determination;

(2) Refer to specific Plan provisions on which the determination is based;

(3) Describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary;

(4) Describe the Plan's review procedures and time limits applicable to such procedures; and

(5) State the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

(c) Appeal of a Denied Claim. If a claimant wants to have the denied claim reviewed, the claimant must send a written request for a review of the claim denial to the Plan no later than 60 days after receiving the claim denial. Any claimant filing a timely request for review may submit additional materials for consideration on review including a written explanation of the issues and comments on the issue. There will be no more than two levels of appeal.

(d) Review of Denied Claim.

(1) Full and Fair Review. A claimant who receives an adverse benefit determination of a claim shall be entitled to a full and fair review of the determination. The claimant may submit with the appeal written comments, documents, records, and other information relating to the claim for benefits. The claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. A document, record or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The Plan's review of the claim shall take into consideration all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan's determination on review shall be binding on all parties.

As other requirements, the review on appeal will not defer to the initial adverse benefit determination. The review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual. If the

adverse benefit determination is based in whole or in part on a medical judgment, an appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Upon request, the Plan will provide the identification of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. The health care professional will not be the same professional who was consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. A health care professional is a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

(2) Time of Decision. The Plan will inform the claimant of the decision on review of an AD&D, Life Insurance or Survivor Income claim within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the Plan. The Plan may determine that an extension of time for processing the claim is required. If an extension is required, the Plan shall provide notice of the extension to the claimant before the end of the initial 60-day period. The notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. The extension of the determination on review shall not exceed a period of 60 days from the end of the initial period.

(3) Content of Denial Notice on Review. The notification of a determination on review will:

[a] State the specific reasons or reasons for the adverse determination;

[b] Refer to the specific Plan provisions on which the benefit determination is based;

[c] State that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

[d] State the claimant's right to bring an action under section 502(a) of ERISA; and

[e] Notify the claimant of any additional voluntary appeal procedures offered by the Plan, if any.

6.5 **Calculation of Time Periods.** The period of time for making a benefit determination shall begin when a claim is filed in accordance with the reasonable filing procedures of the Plan, without regard to whether all of the information necessary to decide the claim accompanies the filing. Days are measured in calendar days. If the time period is extended during the initial benefit determination due to the claimant's failure to submit information necessary to decide the claim, the time period for processing the claim is suspended from the date on which the notice is sent to the claimant to the date the Plan receives the claimant's response, or the time period specified by the Plan, if later. If instead the time period was extended during the benefit determination on review due to the claimant's failure to submit information necessary to decide the claim, the time period for processing the claim is suspended from the date on which the notice is sent to the claimant to the date the Plan receives the claimant's response to the request.

6.6 **Further Action.** In the event a claim for benefits has been denied, no lawsuit or other action against the Plan or the insurance Carrier may be filed until the matter has been submitted for review in accordance with the claims appeal provisions set forth in this Article VI. Further, in the event a claim has been submitted for review in accordance with such procedures and the claim has again been denied, no lawsuit or other action against the Plan may be filed after 180 days from the date the claimant has been given written notice of the Plan's decision on his appeal.

If the time limitation in this section of the Plan is less than that required by law, such limitation is hereby extended to conform to the minimum period permitted by law.

6.7 **Deemed Exhaustion of Remedies.** If the Plan fails to follow these procedures in accordance with applicable law, a claimant shall be deemed to have exhausted the administrative remedies available under the Plan. The claimant shall be entitled to pursue any available remedies under section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of a claim.

6.8 **Authorized Representative of Claimant.** The Plan's claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. The Plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the claimant. In the absence of contrary direction from the claimant, the Plan will direct all information and notifications to the representative authorized to act on the claimant's behalf.

6.9 **State Insurance Law.** Nothing in the claims procedures in this Article VI is intended to preempt any provision of state law that regulates insurance, except to the extent that the state law prevents the application of a requirement of the claims procedures.

6.10 **Electronic Notification.** Electronic notification by the Plan shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii) and (iv).

6.11 **Mailing Presumption.** The Plan relies on a general presumption that a notice sent by first class mail will be received within 5 business days of mailing.

ARTICLE VII

HIPAA PRIVACY AND SECURITY

7.1 **Protected Health Information.** The Plan is a hybrid entity that covers both health and non-health benefits. This Article VII only applies to those Benefit Components that are defined as a health plan pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Privacy and Security Regulations"). The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the Privacy and Security Regulations. The capitalized terms of art used below are as defined by the Privacy and Security Regulations. The following provisions address disclosures of PHI to the Plan Sponsor, Case New Holland, Inc., for Plan administration purposes.

7.2 **Disclosure of PHI to the Plan Sponsor.**

(a) Disclosures by Plan. The Plan may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.

(b) Disclosures by Business Associates. The Plan's Business Associates may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.

(c) Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform the following Plan administration functions:

(1) the Plan's Payment activities,

(2) those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and

(3) all of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

7.3 **Uses and Disclosures of PHI by the Plan Sponsor**. The Plan Sponsor shall use and/or disclose PHI only to the extent necessary to perform Plan administration functions that qualify as Payment or Health Care Operations, or as otherwise permitted or required by the Privacy Regulations.

7.4 **Privacy Safeguards.** The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

(b) Ensure that any subcontractors or agents to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

(d) Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

(e) Report to the Plan any use or disclosure of PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the Plan;

(f) Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(h) Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;

(j) If feasible, return or destroy all PHI that the Plan Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Plan Sponsor. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and

(k) Ensure that adequate separation between the Plan and the Plan Sponsor is established, as described below.

7.5 **Adequate Separation.** In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

Corporate Benefits
Benefits Administrative Committee
Accounts Payable
Internal Audit
Treasury Department

7.6 **Limitations of PHI Access and Disclosure.** The persons described in section 7.5 may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan as described above.

7.7 **Noncompliance Issues.** If the persons described in section 7.5 do not comply with these privacy requirements, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

7.8 **Security Provisions.** This section applies to electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (1) it receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (2) that qualifies as Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508).

(a) Security Safeguards. The Plan Sponsor shall, in accordance with the Security Regulations:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan.

(2) Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any Employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan Sponsor's disciplinary procedures.

(3) Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

(4) Report to the Plan any Security Incident of which it becomes aware in accordance with the Plan's security policy.

(b) Security Official. The Plan shall designate a Security Official, in accordance with 45 C.F.R. section 164.308(a)(2), who will be responsible for the development and implementation of the policies and procedures required under the Security Regulations.

7.9 **Effective Date.** Sections 7.1 through 7.7 of this Article VII shall be effective as of April 14, 2003. Section 7.8 of this Article VII shall be effective as of April 20, 2005.

ARTICLE VIII

SUBROGATION

8.1 **Plan's Right to Subrogation.** To the extent of any payments the Plan makes or may be obliged to make for a claim ("Claim") pursuant to any of the self-funded Benefit Components described in Appendix I, the Plan shall be subrogated to all rights of recovery of a Participant, his or her parent(s) and dependent(s) or a representative or guardian of the Participant, parent(s) or dependent(s) (collectively referred to as "Claimant") relating to the incident. The subrogation right applies on a priority, first dollar basis to any recovery, whether by suit, settlement or otherwise, whether a partial or full recovery and regardless whether the Claimant is made whole or the manner in which the recovery is characterized, from any source liable for making a payment relating to the injury, illness or condition to which the Claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, financial responsibility, uninsured or underinsured insurance coverages, as well as medical reimbursement coverage purchased by another.

8.2 **Right of Reimbursement.** The Claimant shall first reimburse the Plan on a priority basis for all payments the Plan made or may be obliged to make for the Claim from any recovery from any Source including partial or full recoveries and regardless whether the Claimant is made whole or the manner in which the recovery is characterized.

8.3 **Enforcement of Rights.** The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests under this provision through any appropriate legal or equitable remedy, including but not limited to the initiation of a collection action under ERISA or applicable federal or state law, intervention in legal action initiated by the Claimant, the imposition of a constructive trust or the filing of a claim for equitable restitution against any recipient of monies recovered through settlement, judgment or otherwise. The Plan's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

Further, where the Claimant or its agent receives a recovery from any Source but does not reimburse the Plan, the Plan shall have the right to reduce future benefits on the claims submitted by the Claimant and eligible dependents associated with the Claimant until the Plan has recovered the full amount allowed under this provision.

The Plan may pursue its claims against the Claimant's heirs, successors and assigns.

8.4 **Action Required of Claimant**. If requested in writing by the Plan Administrator, the Claimant or the Claimant's authorized representative shall take such action as necessary or appropriate to recover, as damages, payments made by the Plan. If a Claimant fails or refuses to take such action, the Plan shall be entitled to do so in the Claimant's name against any Source liable therefor.

The Plan shall possess an equitable lien that will attach to any recovery to the extent of the Plan's subrogation and reimbursement interests. The Claimant shall hold in trust for the Plan's benefit any money recovered from any Source. The Claimant shall reimburse the Plan immediately upon recovery. However, the Claimant shall retain any amount greater than the aggregate of:

(a) the amount paid or which the Plan may be obliged to pay for claims incurred and

(b) the costs, expenses and attorney's fees the Plan incurred to enforce the Plan's rights.

The Claimant shall immediately notify the Plan if he or she is involved in or suffers an accident or injury for which a third party may be liable. The Claimant shall again notify the Plan if he or she pursues a Claim to recover damages or other relief relating to a Claim. The Claimant shall do nothing to impair, release, discharge or prejudice the Plan's rights referred to in this subrogation provision. The Claimant shall assist and cooperate with representatives the Plan designates. The Claimant shall do everything necessary to enable the Plan to enforce its subrogation rights. The Claimant shall immediately notify the Plan upon receiving a settlement or compromise offer and shall not settle or compromise any claims without the Plan's consent. The Claimant shall also immediately notify the Plan upon obtaining any judgment relating to a Claim.

Claims relating to the Claim which are incurred after a recovery shall be the responsibility of the Claimant to the extent of the Claimant's net recovery and shall be paid by the Claimant and not the Plan. In the event the Plan inadvertently provides benefits for such a Claim, the Claimant shall have an obligation to repay the Plan to the extent of the Claimant's net recovery. The Plan has the enforcement rights set forth in paragraph (c) above to recover such amounts. In situations where a Claimant has been requested to execute a Subrogation Agreement in a form approved by the Plan Administrator, the Plan Administrator, in its sole discretion, may suspend the processing and payment of any claims

which relate to the incident or condition to which the Plan's subrogation claim relates, until such signed Subrogation Agreement is received by the Plan.

8.5 **Attorneys' Fees.** The Plan will not be responsible for a Claimant's attorneys' fees or costs unless the Plan has agreed in writing to pay such fees or costs. The Claimant shall be responsible for all costs, fees and expenses the Plan incurs to enforce its subrogation and reimbursement rights.

8.6 **Right to Waive.** The Plan Administrator may waive the above subrogation right or any part thereof, if they decide such action is in the best interest of the Plan, unless determined to be acting in an arbitrary and capricious manner.

ARTICLE IX

GENERAL PROVISIONS

9.1 **Governing Law.** To the extent not preempted by federal law, this Plan shall be interpreted and applied in accordance with the laws of the state of Wisconsin.

9.2 **No Guarantee of Tax Consequences.** The Plan Administrator and Employers do not guarantee that benefits will be excluded from the Participant's gross income for federal or state income tax purposes, or that any other tax treatment will be available to the Participant.

9.3 **Severability.** If any provision of this Plan is invalid due to a change in legal requirements, or another legal reason, that provision shall not be valid. The remainder of the Plan shall continue in effect.

APPENDIX I

CNH HEALTH AND WELFARE PLAN

BENEFIT COMPONENTS

The terms, conditions and limitations of the benefits described in the Plan are contained in the Benefit Components listed in this Appendix which are incorporated herein by reference.

A. Benefit Documents. The following documents describe the Benefit Components:

1. Medical Program Summary Plan Description
2. Dental Program Summary Plan Description
3. Vision Program Summary Plan Description
4. Disability Program Summary Plan Description (Salaried)
5. Disability Program Summary Plan Description (Hourly)
6. Flexible Spending Accounts Summary Plan Description
7. Life and Accident Program Summary Plan Description
8. Survivor Income Benefit Summary Plan Description (Hourly)
9. Eligibility Supplement for Salaried Employees
10. Eligibility Supplement for Hourly Employees
11. CNH Separation Allowance Policy for Salaried Employees
12. Employee Group Insurance Plan for Hourly Employees of CNH Participating Employers - Fargo, International Association of Machinists and Aerospace Workers Summary Plan Description
13. Employee Group Insurance Plan for Hourly Employees of Case New Holland, Inc. –United Auto Workers Summary Plan Description
14. Employee Insurance Plan for Hourly Employees of Case Corporation - United Auto Workers Summary Plan Description
15. Wellness Benefit Program
16. Humana Group Medicare PFFS Plan Guide

B. Medical Benefits provided through insurance contracts:

Description	Carrier	Policy Number
Medicare Advantage Plan	Humana	PFFS 078 052
Medical Plan for Fargo Union (IAM)	National IAM Benefit Trust	H001

C. Medical Benefits provided on a self-funded basis:

Description	Administrative Services Agreement
Network based Medical Options	Anthem BCBS
Non-Network based Medical Options	Anthem BCBS
Prescription Drugs	Medco

E. Dental Benefits provided on a self-funded basis:

Description	Administrative Service Agreement
Traditional Dental Plan	Delta Dental of Wisconsin
Dental Network Plan	Delta Dental of Wisconsin
Indemnity Dental Plan (UAW)	Delta Dental of Wisconsin
Dental Plan (Fargo Machinists)	Delta Dental of Wisconsin

F. Vision Benefits provided on a self-funded basis:

Description	Administrative Service Agreement
Vision Plan	Vision Service Plan

G. Accidental Death and Dismemberment/Life Insurance Benefits provided through insurance contracts:

Description	Carrier	Policy Number
Accidental Death and Dismemberment Basic	AIG	BSC8064415
Accidental Death and Dismemberment Supplemental	AIG	PAI8064416
Life Insurance – Basic and Supplemental	SunLife	63354

H. Survivor Income Benefits provided through insurance contracts:

Description	Carrier	Policy Number
Survivor Income Plan	SunLife	63354

I. Flexible Spending Accounts provided on a self-funded basis:

Description	Administrative Service Agreement
Health Care Spending Account	Anthem BCBS
Dependent Care Spending Account	Anthem BCBS

J. Disability Benefits provided through insurance contracts:

Description	Carrier	Policy Number
Long Term Disability Insurance	Prudential	DG-01066-NJ

K. Disability Benefits provided on a self-funded basis:

Description	Administrative Service Agreement
Accident & Sickness benefit (union)	Prudential
Short Term Disability	N/A – CNH Self-administered
Long Term Disability (union)	Prudential

L. Separation Benefits provided on a self-funded basis:

Description	Administrative Service Agreement
Separation Benefits	N/A – CNH Self-administered

M. Wellness Benefits provided on a self-funded basis:

Description	Administrative Service Agreement
The Picture of Health	HealthFitness

This Appendix is considered a part of the Plan and may be amended by the Plan Sponsor at any time, for any reason, without consent of any person, except as otherwise provided by law.

APPENDIX II

CNH HEALTH AND WELFARE PLAN

LIST OF PARTICIPATING EMPLOYERS AND LEGAL ENTITIES

The following Employers shall be considered "Participating Employers" under the Plan:

CNH America LLC
Case Credit Corporation
Fiatallis North America, Inc.
New Holland Credit Company, LLC
Case Dealer Holding Company (d/b/a Case Power Equipment)
Any other subsidiary or affiliate of the Plan Sponsor, Case New Holland, Inc., that adopts the plan.

This Appendix is considered a part of the Plan and may be amended by the Plan Sponsor at any time, for any reason, without consent of any person, except as otherwise provided by law.

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